

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1429

## CERTIFICATE OF DEATH

Reg. Dist. No.

01411

1. PLACE OF DEATH a. COUNTY <u>A.A. COUNTY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIVERDALE ON MAGOTHY</u>				c. LENGTH OF STAY IN 1b <u>3 MOS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BOX 178, RTE. 2, SEVERNA PARK</u>				e. STREET ADDRESS <u>804 E. CROSS ST.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>NORMA P. ARNETT</u>				4. DATE OF DEATH Month Day Year <u>2 11 1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 14, 1891</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN BUTLER</u>				14. MOTHER'S MAIDEN NAME <u>FENTON WHEELER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>LOUIS ARNETT 902 ANDREWS AVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized edema</u> <u>443X</u> DUE TO <u>Cardiac Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>6 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb 10/61</u> to <u>Feb 11, 1961</u> , that I last saw the deceased alive on <u>2/10/61</u> , 19 <u>61</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Saac Miller M.D.</u>				DATE SIGNED <u>12-25-61</u>			
PHYSICIAN'S NAME (Type) <u>DR. SAAC MILLER</u>				ADDRESS <u>BALTO 30 ME 1961</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/15/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>		22d. LOCATION (City, town, or county) (State) <u>A.A.CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dr. Hoffmann</u>				ADDRESS <u>3218 HUDSON ST. BALTO MD.</u>		24a. REC'D BY REGISTRAR DATE <u>1 4 61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur J. Kuntz</u>							

CERTIFICATE OF DEATH

1-1-50

NAME OF DECEASED <i>John Doe</i>		DATE OF DEATH <i>Jan 1 1950</i>
AGE <i>45</i>		SEX <i>Male</i>
RACE <i>White</i>		EDUCATION <i>High School</i>
OCCUPATION <i>Teacher</i>		RESIDENCE <i>123 Main St, New York, N.Y.</i>
CAUSE OF DEATH <i>Heart Disease</i>		PLACE OF DEATH <i>Home</i>
MANNER OF DEATH <i>Natural</i>		DATE OF BURIAL <i>Jan 3 1950</i>
PLACE OF BURIAL <i>Catholic Cemetery</i>		NAME OF MINISTER <i>Rev. John Smith</i>
NAME OF PHYSICIAN <i>Dr. John Doe</i>		NAME OF CORONER <i>John Doe</i>
NAME OF REGISTRAR <i>John Doe</i>		NAME OF CLERK <i>John Doe</i>

1430

## CERTIFICATE OF DEATH

Reg. Dist. No. 01412

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Maryland</u>				c. LENGTH OF STAY IN 1b <u>20 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lindamoore</u>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Annapolis, Md.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <u>1 Wilson Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Meriam</u> Middle <u>Minerva</u> Last <u>BARRETT</u>				4. DATE OF DEATH Month <u>February</u> Day <u>22</u> Year <u>19 61</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>31 March 1878</u>	
9. AGE (In years last birthday) <u>82</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USN</u>							
13. FATHER'S NAME <u>George W. TOWNSHEND</u>				14. MOTHER'S MAIDEN NAME <u>Mary California THOMPSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give year or dates of service)				16. SOCIAL SECURITY NO. <u>Not Available</u>		17. INFORMANT <u>MRS. HERMAN KROL</u> Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anemia</u> <u>199</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Abdominal Neoplasm undermined site</u> DUE TO (c) <u>Unknown</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2 February, 19 61</u> to <u>22 February, 19 61</u> , that I last saw the deceased alive on <u>22 February, 19 61</u> , and that death occurred at <u>1010A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital</u> DATE SIGNED <u>22 FEB 61</u>							
ACTUAL SIGNATURE <u>S. Busch</u> M.D. <u>U.S. Naval Hospital</u>				DATE SIGNED <u>22 FEB 61</u>			
PHYSICIAN'S NAME (Type) <u>S. BUSCH LT MC USNR</u>				Address <u>Annapolis, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-25-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ALL HALLOWS</u>		22d. LOCATION (City, town, or county) (State) <u>DAVIDSONVILLE Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor &amp; Sons</u>				ADDRESS <u>Annapolis, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 27 '61</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1430

01419

CRAIG L. WILSON, JR.

<p>1. Name of deceased: <u>CRAIG L. WILSON, JR.</u></p>	
<p>2. Date of death: <u>10/10/1991</u></p>	
<p>3. Place of death: <u>At home</u></p>	
<p>4. Cause of death: <u>Heart failure</u></p>	
<p>5. Manner of death: <u>Natural</u></p>	
<p>6. Age at death: <u>45</u></p>	
<p>7. Sex: <u>Male</u></p>	
<p>8. Race: <u>White</u></p>	
<p>9. Marital status: <u>Married</u></p>	
<p>10. Occupation: <u>Software Engineer</u></p>	
<p>11. Education: <u>College</u></p>	
<p>12. Date of birth: <u>10/10/1946</u></p>	
<p>13. Date of death: <u>10/10/1991</u></p>	
<p>14. Place of death: <u>At home</u></p>	
<p>15. Cause of death: <u>Heart failure</u></p>	
<p>16. Manner of death: <u>Natural</u></p>	
<p>17. Age at death: <u>45</u></p>	
<p>18. Sex: <u>Male</u></p>	
<p>19. Race: <u>White</u></p>	
<p>20. Marital status: <u>Married</u></p>	
<p>21. Occupation: <u>Software Engineer</u></p>	
<p>22. Education: <u>College</u></p>	
<p>23. Date of birth: <u>10/10/1946</u></p>	
<p>24. Date of death: <u>10/10/1991</u></p>	
<p>25. Place of death: <u>At home</u></p>	
<p>26. Cause of death: <u>Heart failure</u></p>	
<p>27. Manner of death: <u>Natural</u></p>	
<p>28. Age at death: <u>45</u></p>	
<p>29. Sex: <u>Male</u></p>	
<p>30. Race: <u>White</u></p>	
<p>31. Marital status: <u>Married</u></p>	
<p>32. Occupation: <u>Software Engineer</u></p>	
<p>33. Education: <u>College</u></p>	
<p>34. Date of birth: <u>10/10/1946</u></p>	
<p>35. Date of death: <u>10/10/1991</u></p>	
<p>36. Place of death: <u>At home</u></p>	
<p>37. Cause of death: <u>Heart failure</u></p>	
<p>38. Manner of death: <u>Natural</u></p>	
<p>39. Age at death: <u>45</u></p>	
<p>40. Sex: <u>Male</u></p>	
<p>41. Race: <u>White</u></p>	
<p>42. Marital status: <u>Married</u></p>	
<p>43. Occupation: <u>Software Engineer</u></p>	
<p>44. Education: <u>College</u></p>	
<p>45. Date of birth: <u>10/10/1946</u></p>	
<p>46. Date of death: <u>10/10/1991</u></p>	
<p>47. Place of death: <u>At home</u></p>	
<p>48. Cause of death: <u>Heart failure</u></p>	
<p>49. Manner of death: <u>Natural</u></p>	
<p>50. Age at death: <u>45</u></p>	
<p>51. Sex: <u>Male</u></p>	
<p>52. Race: <u>White</u></p>	
<p>53. Marital status: <u>Married</u></p>	
<p>54. Occupation: <u>Software Engineer</u></p>	
<p>55. Education: <u>College</u></p>	
<p>56. Date of birth: <u>10/10/1946</u></p>	
<p>57. Date of death: <u>10/10/1991</u></p>	
<p>58. Place of death: <u>At home</u></p>	
<p>59. Cause of death: <u>Heart failure</u></p>	
<p>60. Manner of death: <u>Natural</u></p>	
<p>61. Age at death: <u>45</u></p>	
<p>62. Sex: <u>Male</u></p>	
<p>63. Race: <u>White</u></p>	
<p>64. Marital status: <u>Married</u></p>	
<p>65. Occupation: <u>Software Engineer</u></p>	
<p>66. Education: <u>College</u></p>	
<p>67. Date of birth: <u>10/10/1946</u></p>	
<p>68. Date of death: <u>10/10/1991</u></p>	
<p>69. Place of death: <u>At home</u></p>	
<p>70. Cause of death: <u>Heart failure</u></p>	
<p>71. Manner of death: <u>Natural</u></p>	
<p>72. Age at death: <u>45</u></p>	
<p>73. Sex: <u>Male</u></p>	
<p>74. Race: <u>White</u></p>	
<p>75. Marital status: <u>Married</u></p>	
<p>76. Occupation: <u>Software Engineer</u></p>	
<p>77. Education: <u>College</u></p>	
<p>78. Date of birth: <u>10/10/1946</u></p>	
<p>79. Date of death: <u>10/10/1991</u></p>	
<p>80. Place of death: <u>At home</u></p>	
<p>81. Cause of death: <u>Heart failure</u></p>	
<p>82. Manner of death: <u>Natural</u></p>	
<p>83. Age at death: <u>45</u></p>	
<p>84. Sex: <u>Male</u></p>	
<p>85. Race: <u>White</u></p>	
<p>86. Marital status: <u>Married</u></p>	
<p>87. Occupation: <u>Software Engineer</u></p>	
<p>88. Education: <u>College</u></p>	
<p>89. Date of birth: <u>10/10/1946</u></p>	
<p>90. Date of death: <u>10/10/1991</u></p>	
<p>91. Place of death: <u>At home</u></p>	
<p>92. Cause of death: <u>Heart failure</u></p>	
<p>93. Manner of death: <u>Natural</u></p>	
<p>94. Age at death: <u>45</u></p>	
<p>95. Sex: <u>Male</u></p>	
<p>96. Race: <u>White</u></p>	
<p>97. Marital status: <u>Married</u></p>	
<p>98. Occupation: <u>Software Engineer</u></p>	
<p>99. Education: <u>College</u></p>	
<p>100. Date of birth: <u>10/10/1946</u></p>	
<p>101. Date of death: <u>10/10/1991</u></p>	
<p>102. Place of death: <u>At home</u></p>	
<p>103. Cause of death: <u>Heart failure</u></p>	
<p>104. Manner of death: <u>Natural</u></p>	
<p>105. Age at death: <u>45</u></p>	
<p>106. Sex: <u>Male</u></p>	
<p>107. Race: <u>White</u></p>	
<p>108. Marital status: <u>Married</u></p>	
<p>109. Occupation: <u>Software Engineer</u></p>	
<p>110. Education: <u>College</u></p>	
<p>111. Date of birth: <u>10/10/1946</u></p>	
<p>112. Date of death: <u>10/10/1991</u></p>	
<p>113. Place of death: <u>At home</u></p>	
<p>114. Cause of death: <u>Heart failure</u></p>	
<p>115. Manner of death: <u>Natural</u></p>	
<p>116. Age at death: <u>45</u></p>	
<p>117. Sex: <u>Male</u></p>	
<p>118. Race: <u>White</u></p>	
<p>119. Marital status: <u>Married</u></p>	
<p>120. Occupation: <u>Software Engineer</u></p>	
<p>121. Education: <u>College</u></p>	
<p>122. Date of birth: <u>10/10/1946</u></p>	
<p>123. Date of death: <u>10/10/1991</u></p>	
<p>124. Place of death: <u>At home</u></p>	
<p>125. Cause of death: <u>Heart failure</u></p>	
<p>126. Manner of death: <u>Natural</u></p>	
<p>127. Age at death: <u>45</u></p>	
<p>128. Sex: <u>Male</u></p>	
<p>129. Race: <u>White</u></p>	
<p>130. Marital status: <u>Married</u></p>	
<p>131. Occupation: <u>Software Engineer</u></p>	
<p>132. Education: <u>College</u></p>	
<p>133. Date of birth: <u>10/10/1946</u></p>	
<p>134. Date of death: <u>10/10/1991</u></p>	
<p>135. Place of death: <u>At home</u></p>	
<p>136. Cause of death: <u>Heart failure</u></p>	
<p>137. Manner of death: <u>Natural</u></p>	
<p>138. Age at death: <u>45</u></p>	
<p>139. Sex: <u>Male</u></p>	
<p>140. Race: <u>White</u></p>	
<p>141. Marital status: <u>Married</u></p>	
<p>142. Occupation: <u>Software Engineer</u></p>	
<p>143. Education: <u>College</u></p>	
<p>144. Date of birth: <u>10/10/1946</u></p>	
<p>145. Date of death: <u>10/10/1991</u></p>	
<p>146. Place of death: <u>At home</u></p>	
<p>147. Cause of death: <u>Heart failure</u></p>	
<p>148. Manner of death: <u>Natural</u></p>	
<p>149. Age at death: <u>45</u></p>	
<p>150. Sex: <u>Male</u></p>	
<p>151. Race: <u>White</u></p>	
<p>152. Marital status: <u>Married</u></p>	
<p>153. Occupation: <u>Software Engineer</u></p>	
<p>154. Education: <u>College</u></p>	
<p>155. Date of birth: <u>10/10/1946</u></p>	
<p>156. Date of death: <u>10/10/1991</u></p>	
<p>157. Place of death: <u>At home</u></p>	
<p>158. Cause of death: <u>Heart failure</u></p>	
<p>159. Manner of death: <u>Natural</u></p>	
<p>160. Age at death: <u>45</u></p>	
<p>161. Sex: <u>Male</u></p>	
<p>162. Race: <u>White</u></p>	
<p>163. Marital status: <u>Married</u></p>	
<p>164. Occupation: <u>Software Engineer</u></p>	
<p>165. Education: <u>College</u></p>	
<p>166. Date of birth: <u>10/10/1946</u></p>	
<p>167. Date of death: <u>10/10/1991</u></p>	
<p>168. Place of death: <u>At home</u></p>	
<p>169. Cause of death: <u>Heart failure</u></p>	
<p>170. Manner of death: <u>Natural</u></p>	
<p>171. Age at death: <u>45</u></p>	
<p>172. Sex: <u>Male</u></p>	
<p>173. Race: <u>White</u></p>	
<p>174. Marital status: <u>Married</u></p>	
<p>175. Occupation: <u>Software Engineer</u></p>	
<p>176. Education: <u>College</u></p>	
<p>177. Date of birth: <u>10/10/1946</u></p>	
<p>178. Date of death: <u>10/10/1991</u></p>	
<p>179. Place of death: <u>At home</u></p>	
<p>180. Cause of death: <u>Heart failure</u></p>	
<p>181. Manner of death: <u>Natural</u></p>	
<p>182. Age at death: <u>45</u></p>	
<p>183. Sex: <u>Male</u></p>	
<p>184. Race: <u>White</u></p>	
<p>185. Marital status: <u>Married</u></p>	
<p>186. Occupation: <u>Software Engineer</u></p>	
<p>187. Education: <u>College</u></p>	
<p>188. Date of birth: <u>10/10/1946</u></p>	
<p>189. Date of death: <u>10/10/1991</u></p>	
<p>190. Place of death: <u>At home</u></p>	
<p>191. Cause of death: <u>Heart failure</u></p>	
<p>192. Manner of death: <u>Natural</u></p>	
<p>193. Age at death: <u>45</u></p>	
<p>194. Sex: <u>Male</u></p>	
<p>195. Race: <u>White</u></p>	
<p>196. Marital status: <u>Married</u></p>	
<p>197. Occupation: <u>Software Engineer</u></p>	
<p>198. Education: <u>College</u></p>	
<p>199. Date of birth: <u>10/10/1946</u></p>	
<p>200. Date of death: <u>10/10/1991</u></p>	
<p>201. Place of death: <u>At home</u></p>	
<p>202. Cause of death: <u>Heart failure</u></p>	
<p>203. Manner of death: <u>Natural</u></p>	
<p>204. Age at death: <u>45</u></p>	
<p>205. Sex: <u>Male</u></p>	
<p>206. Race: <u>White</u></p>	
<p>207. Marital status: <u>Married</u></p>	
<p>208. Occupation: <u>Software Engineer</u></p>	
<p>209. Education: <u>College</u></p>	
<p>210. Date of birth: <u>10/10/1946</u></p>	
<p>211. Date of death: <u>10/10/1991</u></p>	
<p>212. Place of death: <u>At home</u></p>	
<p>213. Cause of death: <u>Heart failure</u></p>	
<p>214. Manner of death: <u>Natural</u></p>	
<p>215. Age at death: <u>45</u></p>	
<p>216. Sex: <u>Male</u></p>	
<p>217. Race: <u>White</u></p>	
<p>218. Marital status: <u>Married</u></p>	
<p>219. Occupation: <u>Software Engineer</u></p>	
<p>220. Education: <u>College</u></p>	
<p>221. Date of birth: <u>10/10/1946</u></p>	
<p>222. Date of death: <u>10/10/1991</u></p>	
<p>223. Place of death: <u>At home</u></p>	
<p>224. Cause of death: <u>Heart failure</u></p>	
<p>225. Manner of death: <u>Natural</u></p>	
<p>226. Age at death: <u>45</u></p>	
<p>227. Sex: <u>Male</u></p>	
<p>228. Race: <u>White</u></p>	
<p>229. Marital status: <u>Married</u></p>	
<p>230. Occupation: <u>Software Engineer</u></p>	
<p>231. Education: <u>College</u></p>	
<p>232. Date of birth: <u>10/10/1946</u></p>	
<p>233. Date of death: <u>10/10/1991</u></p>	
<p>234. Place of death: <u>At home</u></p>	
<p>235. Cause of death: <u>Heart failure</u></p>	
<p>236. Manner of death: <u>Natural</u></p>	
<p>237. Age at death: <u>45</u></p>	
<p>238. Sex: <u>Male</u></p>	
<p>239. Race: <u>White</u></p>	
<p>240. Marital status: <u>Married</u></p>	
<p>241. Occupation: <u>Software Engineer</u></p>	
<p>242. Education: <u>College</u></p>	
<p>243. Date of birth: <u>10/10/1946</u></p>	
<p>244. Date of death: <u>10/10/1991</u></p>	
<p>245. Place of death: <u>At home</u></p>	
<p>246. Cause of death: <u>Heart failure</u></p>	
<p>247. Manner of death: <u>Natural</u></p>	
<p>248. Age at death: <u>45</u></p>	
<p>249. Sex: <u>Male</u></p>	
<p>250. Race: <u>White</u></p>	
<p>251. Marital status: <u>Married</u></p>	
<p>252. Occupation: <u>Software Engineer</u></p>	
<p>253. Education: <u>College</u></p>	
<p>254. Date of birth: <u>10/10/1946</u></p>	
<p>255. Date of death: <u>10/10/1991</u></p>	
<p>256. Place of death: <u>At home</u></p>	
<p>257. Cause of death: <u>Heart failure</u></p>	
<p>258. Manner of death: <u>Natural</u></p>	
<p>259. Age at death: <u>45</u></p>	
<p>260. Sex: <u>Male</u></p>	
<p>261. Race: <u>White</u></p>	
<p>262. Marital status: <u>Married</u></p>	
<p>263. Occupation: <u>Software Engineer</u></p>	
<p>264. Education: <u>College</u></p>	
<p>265. Date of birth: <u>10/10/1946</u></p>	
<p>266. Date of death: <u>10/10/1991</u></p>	
<p>267. Place of death: <u>At home</u></p>	
<p>268. Cause of death: <u>Heart failure</u></p>	
<p>269. Manner of death: <u>Natural</u></p>	
<p>270. Age at death: <u>45</u></p>	
<p>271. Sex: <u>Male</u></p>	
<p>272. Race: <u>White</u></p>	
<p>273. Marital status: <u>Married</u></p>	
<p>274. Occupation: <u>Software Engineer</u></p>	
<p>275. Education: <u>College</u></p>	
<p>276. Date of birth: <u>10/10/1946</u></p>	
<p>277. Date of death: <u>10/10/1991</u></p>	
<p>278. Place of death: <u>At home</u></p>	
<p>279. Cause of death: <u>Heart failure</u></p>	
<p>280. Manner of death: <u>Natural</u></p>	
<p>281. Age at death: <u>45</u></p>	
<p>282. Sex: <u>Male</u></p>	
<p>283. Race: <u>White</u></p>	
<p>284. Marital status: <u>Married</u></p>	
<p>285. Occupation: <u>Software Engineer</u></p>	
<p>286. Education: <u>College</u></p>	
<p>287. Date of birth: <u>10/10/1946</u></p>	
<p>288. Date of death: <u>10/10/1991</u></p>	
<p>289. Place of death: <u>At home</u></p>	
<p>290. Cause of death: <u>Heart failure</u></p>	
<p>291. Manner of death: <u>Natural</u></p>	
<p>292. Age at death: <u>45</u></p>	
<p>293. Sex: <u>Male</u></p>	
<p>294. Race: <u>White</u></p>	
<p>295. Marital status: <u>Married</u></p>	
<p>296. Occupation: <u>Software Engineer</u></p>	
<p>297. Education: <u>College</u></p>	
<p>298. Date of birth: <u>10/10/1946</u></p>	
<p>299. Date of death: <u>10/10/1991</u></p>	
<p>300. Place of death: <u>At home</u></p>	
<p>301. Cause of death: <u>Heart failure</u></p>	
<p>302. Manner of death: <u>Natural</u></p>	
<p>303. Age at death: <u>45</u></p>	
<p>304. Sex: <u>Male</u></p>	
<p>305. Race: <u>White</u></p>	
<p>306. Marital status: <u>Married</u></p>	
<p>307. Occupation: <u>Software Engineer</u></p>	
<p>308. Education: <u>College</u></p>	
<p>309. Date of birth: <u>10/10/1946</u></p>	
<p>310. Date of death: <u>10/10/1991</u></p>	
<p>311. Place of death: <u>At home</u></p>	
<p>312. Cause of death: <u>Heart failure</u></p>	
<p>313. Manner of death: <u>Natural</u></p>	
<p>314. Age at death: <u>45</u></p>	
<p>315. Sex: <u>Male</u></p>	
<p>316. Race: <u>White</u></p>	
<p>317. Marital status: <u>Married</u></p>	
<p>318. Occupation: <u>Software Engineer</u></p>	
<p></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1431

01413

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - Annapolis</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>		e. STREET ADDRESS <b>Bembe's Beach</b>	
3. NAME OF DECEASED (Type or print) First <b>Lillian</b> Middle <b>C.</b> Last <b>BEMBE</b>		4. DATE OF DEATH Month <b>February</b> Day <b>7</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 25, 1894</b>
9. AGE (In years last birthday) <b>66 yrs.</b>		10. IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min. <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Werner</b>		14. MOTHER'S MAIDEN NAME <b>Sophia Butzler</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Carl C. F. Bembe</b>		Address <b>(2)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Azotemia</b> <b>592x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic nephritis with nephrosis</b> DUE TO (c) <b>Dia beta mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>2 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Dia beta mellitus</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Annapolis Md</b>	
21. I certify that (I) <b>physician</b> attended the deceased from <b>Nov. 13, 1960</b> to <b>Feb. 7, 1961</b> that (I) <b>did</b> last saw the deceased alive on <b>Feb. 7, 1960</b> and that death occurred at <b>8:55 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>James R. Martin</b>		22b. DATE SIGNED <b>2-8-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>James R. Martin</b>		22d. ADDRESS <b>6 Shaw St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-10-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Bluff</b>		23d. LOCATION (City, town or county) (State) <b>Annapolis Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor</b>		25. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	
ADDRESS <b>Annapolis Md</b>		25a. REGISTRAR'S SIGNATURE <b>FEB 14 1961</b>	
DATE <b>FEB 14 1961</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	



1150

1151

1150

1151

1151

1150

1151

1150

1151

1150

1151

1150

1151

1151

1151

1150

1151

1151

1150

1151

1151

1151

1151

1150

1151

1150

1151

1150

1151

1151

1151

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1432

## CERTIFICATE OF DEATH

Reg. Dist. No. 01414

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <span style="float: right;">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>26 Years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USNH, ANNAPOLIS, MD.</u>				d. STREET ADDRESS <u>522 1st Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>(n)</u> Last <u>BERGEN</u>				4. DATE OF DEATH Month <u>February</u> Day <u>8th</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-18-97</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Navy</u>		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>David BERGEN</u>		14. MOTHER'S MAIDEN NAME <u>Bertha OSTROM</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>(w) Marian Rita Bergen, 522 1st St., Annapolis,</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Acute pulmonary edema</u>		(b) <u>Chronic silicotic heart disease</u>		(c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u> <u>&gt; 5 years.</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 <u>61</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>23 Jan</u> , 19 <u>61</u> , to <u>8 Feb</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>8 February</u> , 19 <u>61</u> , and that death occurred at <u>8:35 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. B. Hiltibidle</u> M.D.				ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>2-9-61</u>			
PHYSICIAN'S NAME (Type) <u>S. B. HILTBIDLE, LT MC USNR</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-11-1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 14 1961</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1482

<p>1. Name of deceased: _____</p>	
<p>2. Sex: _____</p>	
<p>3. Age: _____</p>	
<p>4. Date of death: _____</p>	
<p>5. Place of death: _____</p>	
<p>6. Cause of death: _____</p>	
<p>7. Signature of physician: _____</p>	
<p>8. Signature of registrar: _____</p>	
<p>9. Signature of informant: _____</p>	
<p>10. Signature of witness: _____</p>	
<p>11. Signature of funeral director: _____</p>	
<p>12. Signature of coroner: _____</p>	
<p>13. Signature of health officer: _____</p>	
<p>14. Signature of registrar: _____</p>	
<p>15. Signature of informant: _____</p>	
<p>16. Signature of witness: _____</p>	
<p>17. Signature of funeral director: _____</p>	
<p>18. Signature of coroner: _____</p>	
<p>19. Signature of health officer: _____</p>	
<p>20. Signature of registrar: _____</p>	
<p>21. Signature of informant: _____</p>	
<p>22. Signature of witness: _____</p>	
<p>23. Signature of funeral director: _____</p>	
<p>24. Signature of coroner: _____</p>	
<p>25. Signature of health officer: _____</p>	
<p>26. Signature of registrar: _____</p>	
<p>27. Signature of informant: _____</p>	
<p>28. Signature of witness: _____</p>	
<p>29. Signature of funeral director: _____</p>	
<p>30. Signature of coroner: _____</p>	
<p>31. Signature of health officer: _____</p>	
<p>32. Signature of registrar: _____</p>	
<p>33. Signature of informant: _____</p>	
<p>34. Signature of witness: _____</p>	
<p>35. Signature of funeral director: _____</p>	
<p>36. Signature of coroner: _____</p>	
<p>37. Signature of health officer: _____</p>	
<p>38. Signature of registrar: _____</p>	
<p>39. Signature of informant: _____</p>	
<p>40. Signature of witness: _____</p>	
<p>41. Signature of funeral director: _____</p>	
<p>42. Signature of coroner: _____</p>	
<p>43. Signature of health officer: _____</p>	
<p>44. Signature of registrar: _____</p>	
<p>45. Signature of informant: _____</p>	
<p>46. Signature of witness: _____</p>	
<p>47. Signature of funeral director: _____</p>	
<p>48. Signature of coroner: _____</p>	
<p>49. Signature of health officer: _____</p>	
<p>50. Signature of registrar: _____</p>	
<p>51. Signature of informant: _____</p>	
<p>52. Signature of witness: _____</p>	
<p>53. Signature of funeral director: _____</p>	
<p>54. Signature of coroner: _____</p>	
<p>55. Signature of health officer: _____</p>	
<p>56. Signature of registrar: _____</p>	
<p>57. Signature of informant: _____</p>	
<p>58. Signature of witness: _____</p>	
<p>59. Signature of funeral director: _____</p>	
<p>60. Signature of coroner: _____</p>	
<p>61. Signature of health officer: _____</p>	
<p>62. Signature of registrar: _____</p>	
<p>63. Signature of informant: _____</p>	
<p>64. Signature of witness: _____</p>	
<p>65. Signature of funeral director: _____</p>	
<p>66. Signature of coroner: _____</p>	
<p>67. Signature of health officer: _____</p>	
<p>68. Signature of registrar: _____</p>	
<p>69. Signature of informant: _____</p>	
<p>70. Signature of witness: _____</p>	
<p>71. Signature of funeral director: _____</p>	
<p>72. Signature of coroner: _____</p>	
<p>73. Signature of health officer: _____</p>	
<p>74. Signature of registrar: _____</p>	
<p>75. Signature of informant: _____</p>	
<p>76. Signature of witness: _____</p>	
<p>77. Signature of funeral director: _____</p>	
<p>78. Signature of coroner: _____</p>	
<p>79. Signature of health officer: _____</p>	
<p>80. Signature of registrar: _____</p>	
<p>81. Signature of informant: _____</p>	
<p>82. Signature of witness: _____</p>	
<p>83. Signature of funeral director: _____</p>	
<p>84. Signature of coroner: _____</p>	
<p>85. Signature of health officer: _____</p>	
<p>86. Signature of registrar: _____</p>	
<p>87. Signature of informant: _____</p>	
<p>88. Signature of witness: _____</p>	
<p>89. Signature of funeral director: _____</p>	
<p>90. Signature of coroner: _____</p>	
<p>91. Signature of health officer: _____</p>	
<p>92. Signature of registrar: _____</p>	
<p>93. Signature of informant: _____</p>	
<p>94. Signature of witness: _____</p>	
<p>95. Signature of funeral director: _____</p>	
<p>96. Signature of coroner: _____</p>	
<p>97. Signature of health officer: _____</p>	
<p>98. Signature of registrar: _____</p>	
<p>99. Signature of informant: _____</p>	
<p>100. Signature of witness: _____</p>	



## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>5 mos. 17 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		<b>3801-4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>516 W. West Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Rose</b>		Middle <b>Anna</b>		Last <b>Boyd</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH Month <b>2</b> Day <b>9</b> Year <b>19 61</b>	
9. AGE (In years last birthday) <b>76</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Unknown</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Inanition and Dehydration</b> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Brain Syndrome asso. Cerebral Arteriosclerosis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour <b>5:45</b> P. M. <b>2/9/61</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that (I) (this hospital) attended the deceased from <b>8/22/60</b> to <b>2/9/61</b> , that (I) (we) last saw the deceased alive on <b>2/9/61</b> , and that death occurred at <b>5:45 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>L. Benedict, M.D.</b>				22b. ADDRESS <b>Crownsville State Hospital, Maryland</b>		22c. DATE SIGNED <b>2/10/61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>2/12/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Warrenton</b>		23d. LOCATION (City, town, or county) (State) <b>Warrenton n. e.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles G. Bare</b>				25a. REC'D BY REGISTRAR <b>FEB 20 61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

UNITED STATES OF AMERICA

SEAL

IN SENATE

January 11, 1901

REPORT

OF THE

COMMISSIONERS

OF THE

LANDS

AND

MINES

IN RESPONSE TO A

RESOLUTION

PASSED

BY THE SENATE

ON JANUARY 11, 1901

1901

1

2

3

4

5

6

7

8

9

10

11

12

Printed by the Government Printing Office

Washington, D. C.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3 FILED 52 3-14-61 et

## CERTIFICATE OF DEATH

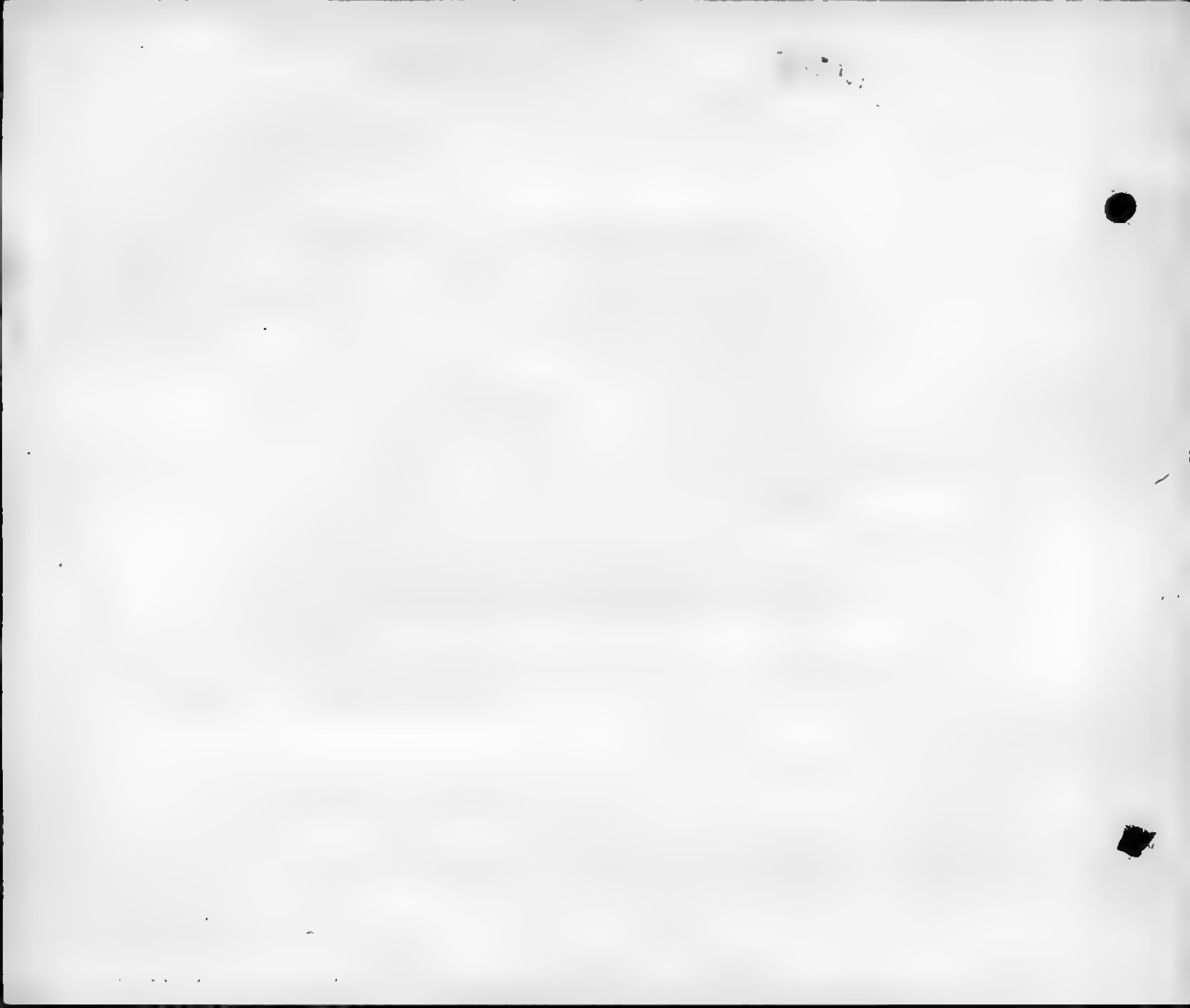
Reg. Dist. No.

01416

1434

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookview Rd</u>				c. LENGTH OF STAY IN 1b <u>23 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Arnold mcd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Benjamin Loraine Brooks</u> First (Lorraine) Middle Last				4. DATE OF DEATH <u>2</u> Month <u>28</u> Day <u>1961</u> Year			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV 6. 1868</u> 92 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ships</u>		11. BIRTHPLACE (State or foreign country) <u>Madison md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph W. Brooks</u>				14. MOTHER'S MAIDEN NAME <u>Tolley - Fournier</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give year or dates of service)				16. SOCIAL SECURITY NO <u>217-16-3433</u>		17. INFORMANT <u>Family</u> Address <u>Above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>51X Intestinal obstruction</u> DUE TO <u>Cocciemia of Stenoch</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cocciemia of Stenoch</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>1960</u> , 19____, to <u>1961</u> , 19____, that I last saw the deceased alive on <u>2-27-61</u> , 19____, and that death occurred at <u>12:05 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert R. Hahn</u>				ADDRESS (Street, city or town, state) <u>Severna Park Md</u>			
PHYSICIAN'S NAME (Type) <u>Severna Park md</u>				DATE SIGNED _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-2-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Calvary Meth. Church Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arnold A.C. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Banane</u>				ADDRESS <u>Severna Park, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 6 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hahn</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1435

## CERTIFICATE OF DEATH

Reg. Dist. No. 01417

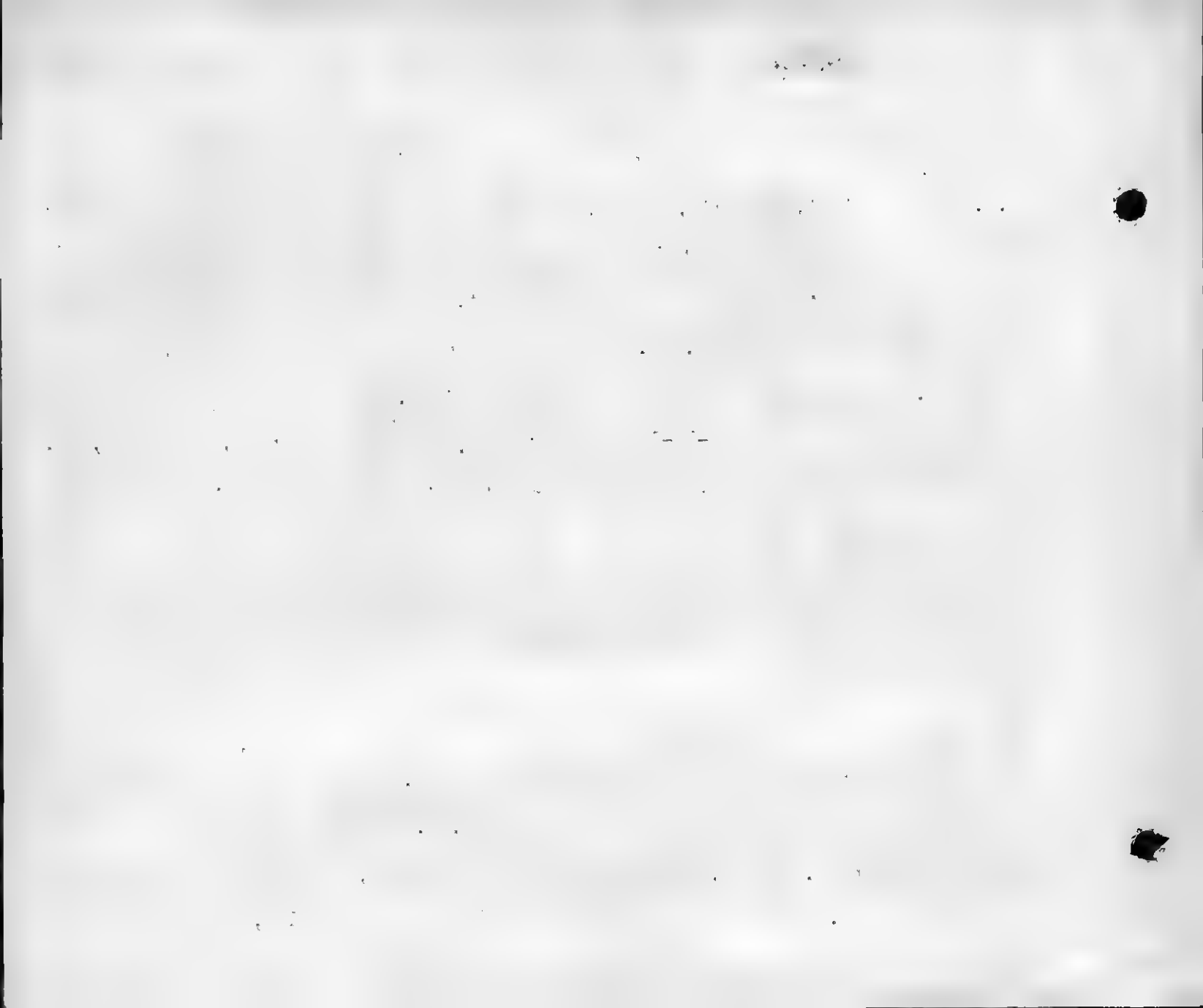
1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. LENGTH OF STAY IN 1b 48 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Annapolis, Maryland		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
3. NAME OF DECEASED (Type or print) First Middle Last Addie Virginia BRYAN		4. DATE OF DEATH Month Day Year February 3 1961	
5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 Oct. 1912
9. AGE (In years last birthday) 48 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Ins. co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME James M. BEALL		14. MOTHER'S MAIDEN NAME Virgie B. KING	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-14-1641	
17. INFORMANT (Daughter) Shriley V. WILLIAMS		Address 1208 MC KINLEY Street, Annapolis, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Ovary with widespread Metastasis DUE TO 175.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 31, 1961, to Feb 3, 1961, that I last saw the deceased alive on Feb 3, 1961, and that death occurred at 6 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Robert D. Belsky		M.D. U. S. NAVAL HOSPITAL	
PHYSICIAN'S NAME (Type) Robert D. BELSKY		17 MC USNR ANNAPOLIS, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 6, 1961	22c. NAME OF CEMETERY OR CREMATORY Annapolis National	22d. LOCATION (City, town, or county) (State) Annapolis, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home Annapolis, Md		24a. REC'D BY REGISTRAR DATE FEB 7 '61	
24b. REGISTRAR'S SIGNATURE C. J. S. P. S.			

MEDICAL CERTIFICATION

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## CERTIFICATE OF DEATH

Reg. Dist. No. 02591

1436

1. PLACE OF DEATH a. COUNTY <i>AA Co.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before adm.ssion) a. STATE b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Severn RFD</i>				c. LENGTH OF STAY IN 1b <i>2-2 yrs.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>854 311 Quarterfield Rd.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Ulysses W. Carroll</i>				4. DATE OF DEATH <i>Feb. 27 1961</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1877</i>	9. AGE (In years last birthday) <i>83</i> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Benfield Md.</i>	
12. FATHER'S NAME <i>John Henry Carroll</i>				14. MOTHER'S MAIDEN NAME <i>Mary Ellen Sappington</i>			
13. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>515 05 5883A</i>		17. INFORMANT <i>Aubrey Brithers - Severn</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-Vascular disease</i>							<i>2-3 mo.</i>
DUE TO (b) <i>Corrosion liver -</i>							<i>54 hrs -</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <i>5/24</i> , 19 <i>61</i> , to <i>2/27</i> , 19 <i>61</i> ; that I last saw the deceased alive on <i>2/27/61</i> , 19 <i>61</i> , and that death occurred at <i>11:45 P.</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Chas. L. Ball Jr.</i> M.D.				ADDRESS (Street, city or town, state) <i>Linthicum</i>			
PHYSICIAN'S NAME (Type) <i>Chas. L. Ball Jr.</i>				DATE SIGNED <i>2/27/61</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-3-61</i>		22c. NAME OF CEMETERY OR CREMATORY <i>John Wesley Cem</i>		22d. LOCATION (City, town, or county) (State) <i>Queentown AAC Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Chas. O. Walker</i> ADDRESS <i>1000 Broadway Ave</i>				24a. REC'D BY REGISTRAR <i>MAR 16 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

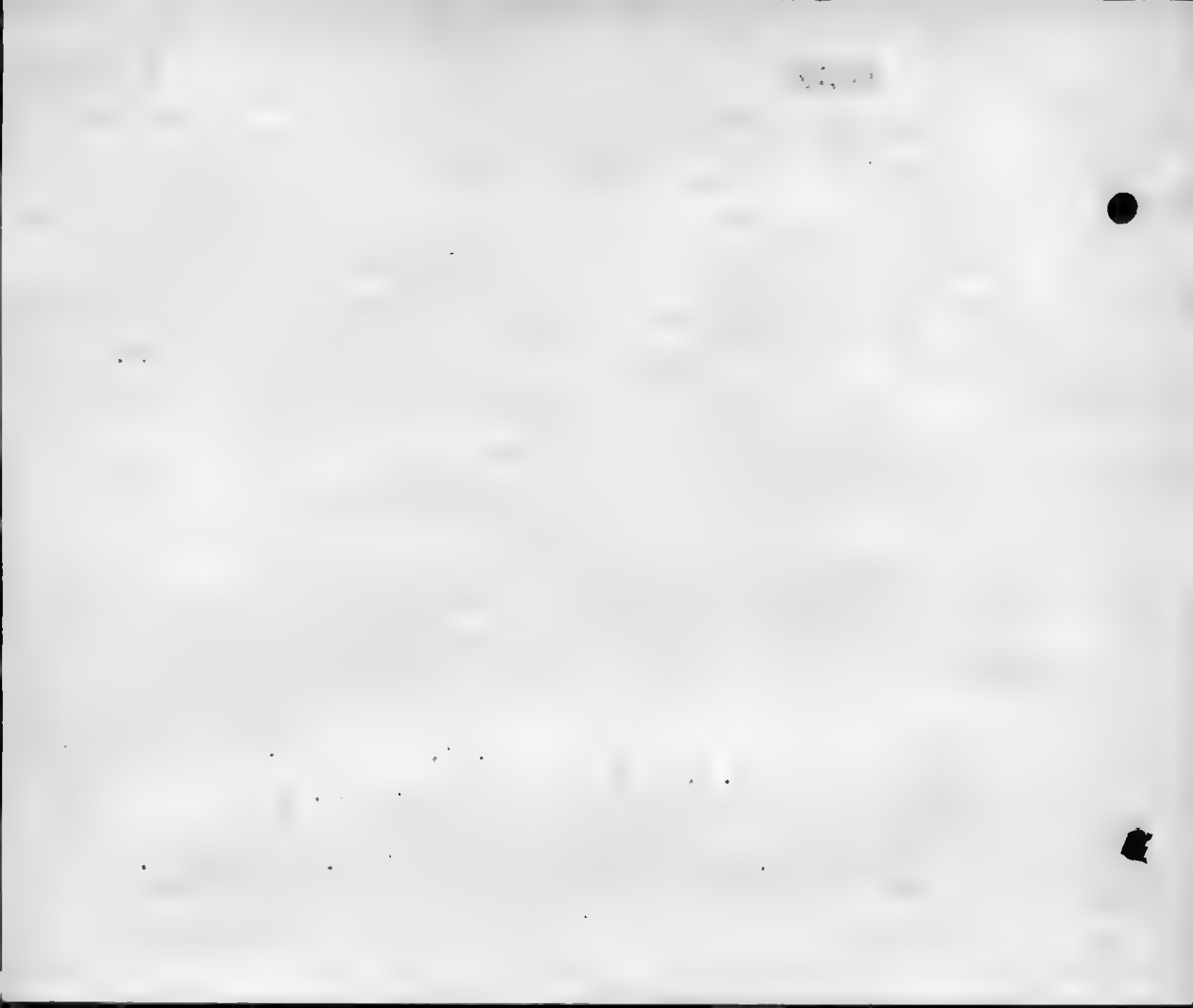
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1437

01418

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>	
c. LENGTH OF STAY IN lb <b>25 days</b>		d. STREET ADDRESS <b>418 Jefferson St</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospice, give street address) <b>Anne Arundel General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>ELEANOR</b> Last <b>CASSADY</b>		DATE OF DEATH <b>February 8 1961</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-1-1889</b>	
9. AGE (In years last birthday) <b>71</b> yrs		10. IF UNDER 1 YEAR Months <b>71</b> Days <b>71</b> Hours <b>71</b> Min. <b>71</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>James Casey</b>		14. MOTHER'S MAIDEN NAME <b>Jeanette Clark</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Mrs Florence J. Barry</b>		Address <b>(2)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> DUE TO <b>Stroke</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Stroke</b> DUE TO <b>Stroke</b> (c) <b>Stroke</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>DIABETES MELLITUS; PERI RECTAL ABSCESS</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20d. (City or town) <b>Annapolis</b>	
20e. (County) <b>Anne Arundel</b>		20f. (State) <b>Md</b>	
21. I certify that (I) <b>James Barry</b> attended the deceased from <b>Jan. 14, 1961</b> , to <b>Feb. 7, 1961</b> , that (I) <b>James Barry</b> saw the deceased alive on <b>Feb. 7, 1961</b> and that death occurred at <b>12:45 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Edward S. Beck</b>		22b. DATE <b>2/8/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edward S. Beck</b>		22d. ADDRESS <b>71 Franklin St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-10-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Annapolis National</b>		23d. LOCATION (City, town or county) <b>Annapolis Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Scully Sr</b>		25a. REC'D BY REGISTRAR <b>FEB 14 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>		25c. DATE <b>FEB 14 '61</b>	





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

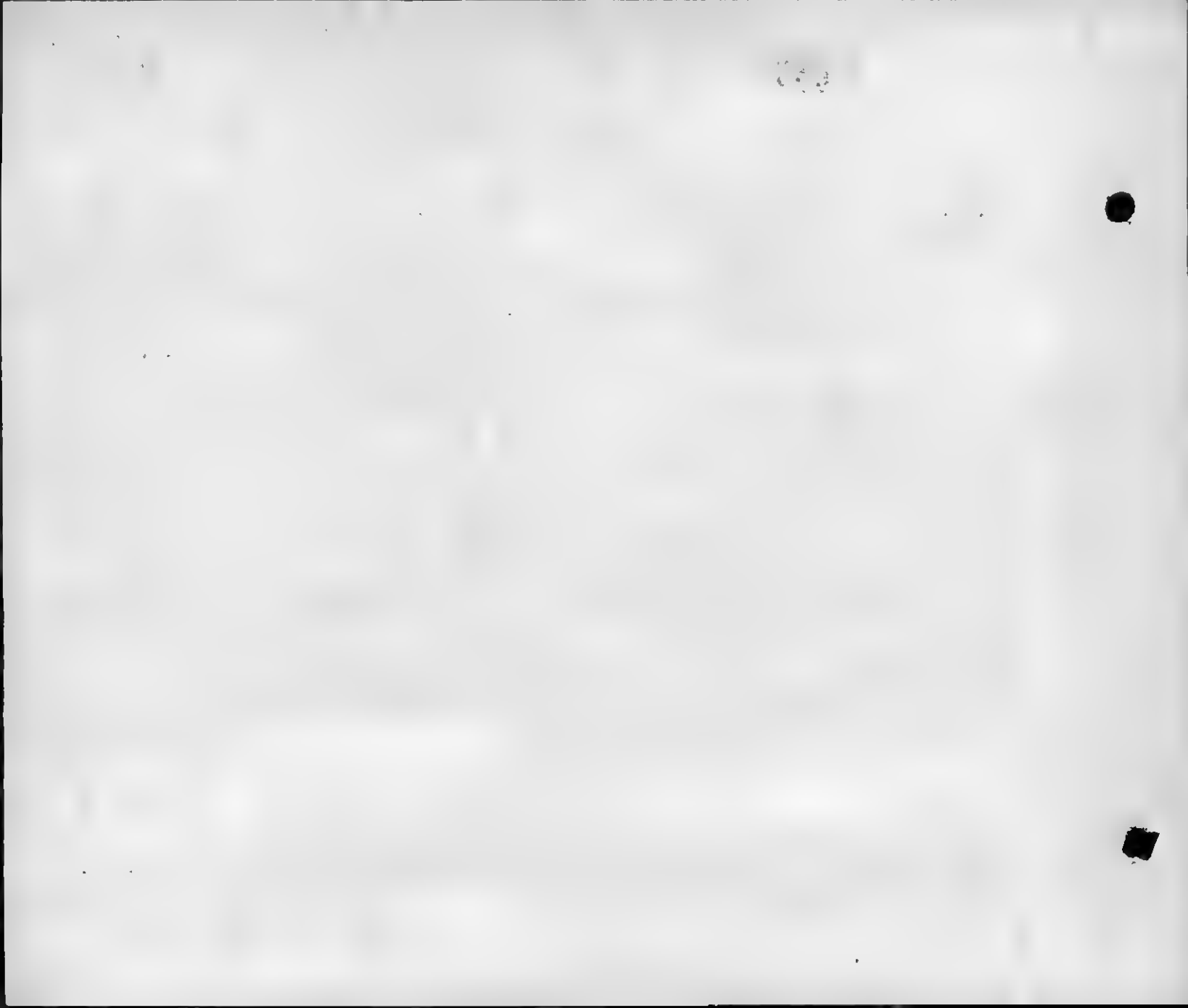
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01419

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort George G. Meade</b> c. LENGTH OF STAY IN 1b <b>15 Hours</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Army Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Res. since before admission on) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Severn</b> d. STREET ADDRESS <b>Route #2, Box 62, Jackson Grove Rd</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Clyde</b>	4. DATE OF DEATH <b>February 15 19 61</b>	5. SEX <b>Male</b>	
6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/28/56</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Oscar Chase</b>	14. MOTHER'S MAIDEN NAME <b>Roberta Jackson</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unknown) <b>N/A</b>	16. SOCIAL SECURITY NO. <b>N/A</b>	17. INFORMANT <b>Parents</b>	
18. CAUSE OF DEATH (Enter only one cause pertinent for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> DUE TO <b>Inhalation of Smoke/Flame</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>Fire in home</b> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fire in home</b> 20c. TIME OF INJURY Month, Day, Year <b>9 Feb 14 61</b> Hour a.m. <b>19</b> p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b> 20f. (City or town) (County) (State) <b>Severn, Anne Arundel, Md</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>17 hrs</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> <b>Gustave H. Faubert</b> ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>GUSTAVE H. FAUBERT</b> M.D. <b>15 February 61</b> DATE SIGNED DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <b>Anne Arundel, Md.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/18/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR <b>Charles A. Rice, 661 W. Barre Street</b>		24a. REC'D BY REGISTRAR <b>FEB 20 '61</b> DATE 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION



## CERTIFICATE OF DEATH

Reg. Dist. No.

01420

1439

1. PLACE OF DEATH o. COUNTY <i>GA Co Md MARYLAND</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <i>Md</i> b. COUNTY <i>GA Co</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i>	c. LENGTH OF STAY IN 1b <i>Life</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X RFD 9-Box 412 Rural</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>RFD 9-Box 412</i>		d. STREET ADDRESS <i>1 Pasadena</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>Walter</i> First <i>Richard</i> Middle <i>Childs</i> Last		4. DATE OF DEATH <i>Feb</i> Month <i>12</i> Day <i>1961</i> Year	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 3-1880</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retiree</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>80</i> yrs. IF UNDER 1 YEAR Months Days Hours Min
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>yes</i>	
13. FATHER'S NAME <i>Samuel Childs</i>		14. MOTHER'S MAIDEN NAME <i>Betty Ward</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>21207-9623</i>	
17. INFORMANT		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Terminal Bronchopneumonia</i> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO (c) <i>Senility</i>		INTERVAL BETWEEN ONSET AND DEATH <i>24 HOURS</i> <i>1 YEAR</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>BRONCHIECTASIS</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>2-12</i> , 1961, to <i>—</i> , 1961, that I last saw the deceased alive on <i>2-12</i> , 1961, and that death occurred at <i>5:45 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>Arthur Lankford Jr.</i> M.D. <i>2934 MOUNTAIN RD.</i> <i>2-12-61</i>		
ACTUAL SIGNATURE <i>ARTHUR LANKFORD JR MD. PASADENA, MARYLAND</i>		
PHYSICIAN'S NAME (Type)		
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY
<i>Rural</i>	<i>Feb 14-61</i>	<i>Baltimore Cemetery</i>
22d. LOCATION (City, town, or county) (State)		
<i>Baltimore City Md</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Frank L. Chapin</i> ADDRESS <i>Blonfurnie Rd.</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 14 '61</i>
		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Lankford</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4

may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

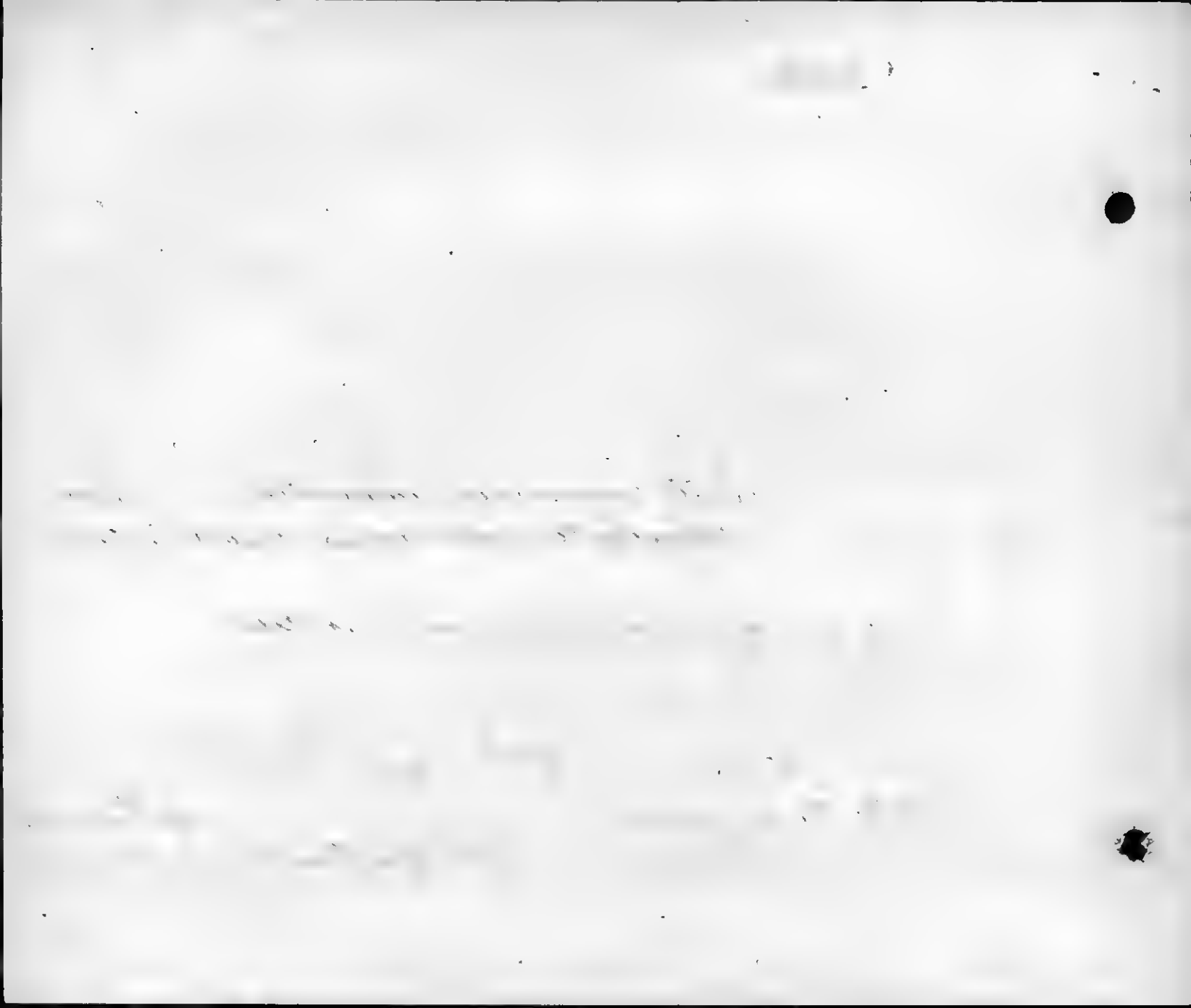
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

01421

1440

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b>		c. LENGTH OF STAY IN 1b <b>35 Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Route 8, Box 26</b>				d. STREET ADDRESS <b>Route 8, Box 26</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Bond</b> Last <b>Cook</b>				4. DATE OF DEATH Month <b>Feb</b> Day <b>7</b> Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov 9, 1874</b>		9. AGE (In years last birthday) <b>86</b> yrs.	IF UNDER 1 YEAR Months <b>7</b> Days <b>1</b> Hours <b>1</b> Min <b>51</b>	IF UNDER 24 HRS. Months <b>7</b> Days <b>1</b> Hours <b>1</b> Min <b>51</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bus Company</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jefferson M. Cook</b>				14. MOTHER'S MAIDEN NAME <b>Emma Linstad</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service.)		16. SOCIAL SECURITY NO. <b>212-410-9199A</b>		17. INFORMANT <b>William Cook, Route 1, Box 10, Pasadena, Md.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardiovascular disease</b> DUE TO (c) <b>3 years</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>generalized hypertrophic osteoarthropathy</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1, 1952</b> to <b>February 4, 1961</b> that (I) (we) last saw the deceased alive on <b>February 1, 1961</b> , and that death occurred at <b>5 A.M.</b> from the causes and on the date stated above							
22a. SIGNATURE <b>R.M. McLaughlin</b>				22b. DATE SIGNED <b>February 4, 1961</b>		22c. PHYSICIAN'S NAME (Type) <b>R.M. McLaughlin</b>	
22d. ADDRESS <b>3708 Mountain Rd. Pasadena, Md.</b>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/7/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Lake Shore, Pasadena, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping &amp; Kirkley, Glen Burnie, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 7 1961</b>		25b. REGISTRAR'S SIGNATURE	

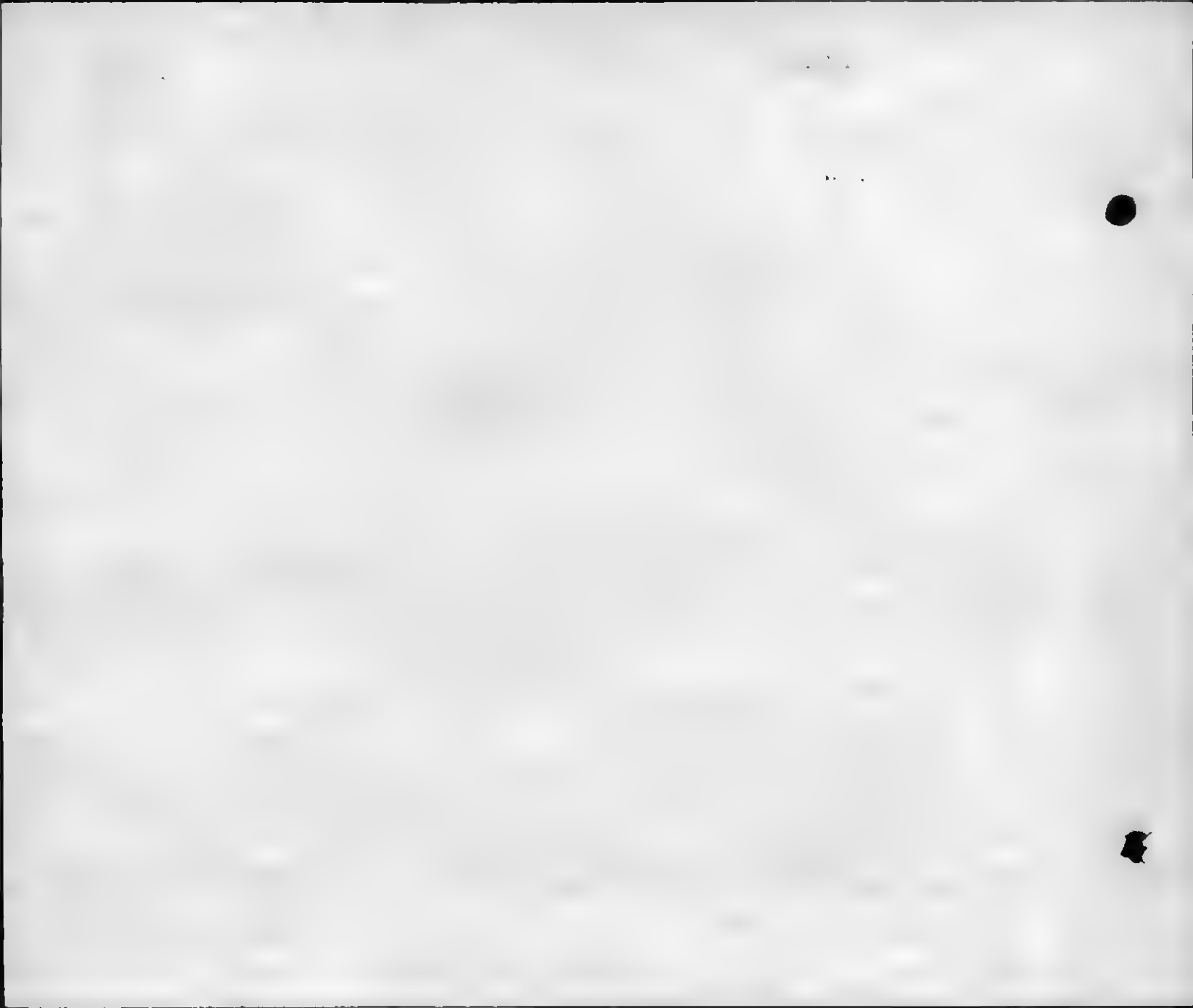




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Nos. 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
1441 CERTIFICATE OF DEATH 01422

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>aa</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mayo</u>	
c. LENGTH OF STAY IN 1b <u>Knollwood Manor</u>		d. STREET ADDRESS <u>1 R 7 S. Edgewater</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Knollwood Manor</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM E. COOK</u>		4. DATE OF DEATH Month <u>2</u> Day <u>14</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug-26-1873</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman Sea Food</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William E. Cook</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ball Jackson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMATION <u>Mrs F. W. Joyce</u>		Address <u>  </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>610X</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO <u>Unemia</u> <u>Pyelo nephritis</u> <u>Prostatism (prostatic hyper trophy)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>weeks</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Cerebro vascular disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that (I) (this hospital) attended the deceased from <u>1/12</u> to <u>2/10</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>2/10</u> , 19 <u>61</u> , and that death occurred at <u>5:15 a.m.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Gerard Church</u>		22b. DATE SIGNED <u>2/10/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>GERARD CHURCH</u>		22d. ADDRESS <u>121 CATHOVORAZ ST ANNAPOLIS</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-17-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St Andrews Cem</u>	23d. LOCATION (City, town or county) (State) <u>Mayo md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sr</u>		25. REC'D BY REGISTRAR DATE <u>FEB 16 '61</u>	
25. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		26. REGISTRAR'S SIGNATURE <u>  </u>	



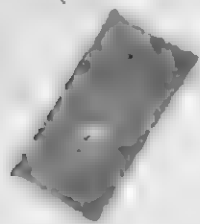
1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please extend the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**1442 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

01423

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Belle Haven, Pasadena</b> c. LENGTH OF STAY IN MD <b>Few hours</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>May wood Rd and Beach Circle Rd.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Same</b> b. COUNTY <b>Same</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> d. STREET ADDRESS <b>1206 Guilford Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>Roy Lee Crews</b>		4. DATE OF DEATH <b>February 11th. 1961</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/24/1924</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Department head at Penn Fruit Store.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>West Virginia.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Milton Crews</b>		14. MOTHER'S MAIDEN NAME <b>Riva Bishan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes, Last world war.</b>		16. SOCIAL SECURITY NO. <b>236-22-9695</b>	
17. INFORMANT <b>Mrs. Iris Crews (wife)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carbon monoxide intoxication</b> Conditions, if any, which gave rise to immediate cause (b) <b>Inhalation of auto exhaust fumes</b> (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Inhalation of carbon monoxide</b>	
20c. TIME OF INJURY Month, Day, Year <b>Hour a.m. 2/11/61</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Parked car</b>	20f. (City or town) (County) (State) <b>Anne Arundel Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>W. Bradley King Jr</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>W. Bradley King Jr MD</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>Feb 11, 1961</b>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>15th Feb. 1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Basham Family Cemetery</b>	22d. LOCATION (City, town, or country) (State) <b>Coal Ridge, W. Virginia</b>
23. FUNERAL DIRECTOR <b>R. G. Singleton</b>		ADDRESS <b>Glen Burnie, Maryland</b>	
24a. RECEIVED BY REGISTRAR <b>Feb 14 61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Khan</b>	





## Reg. Dist. No.

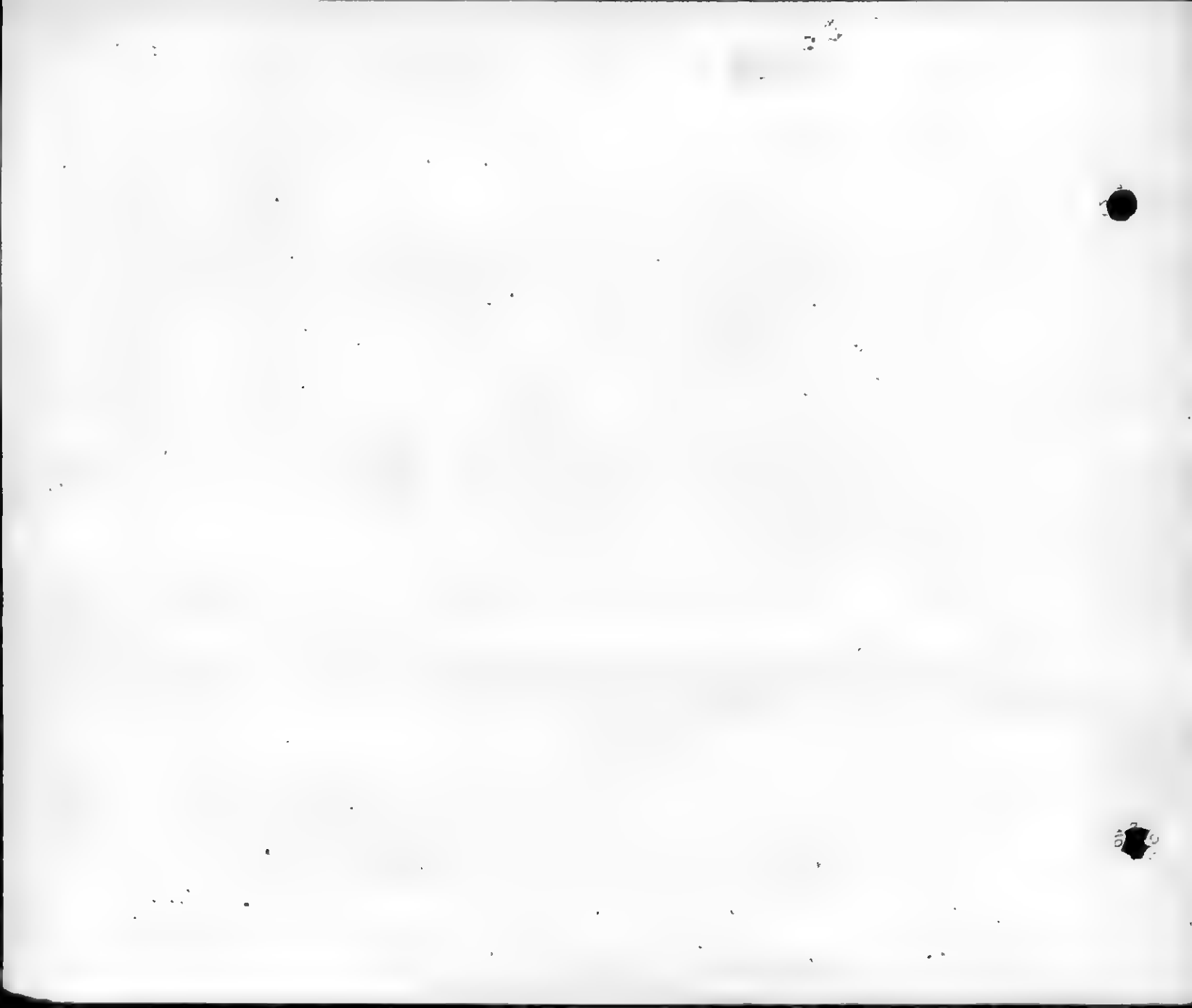
1443



X

①

VS AIS (4)  
ISM 9/SB



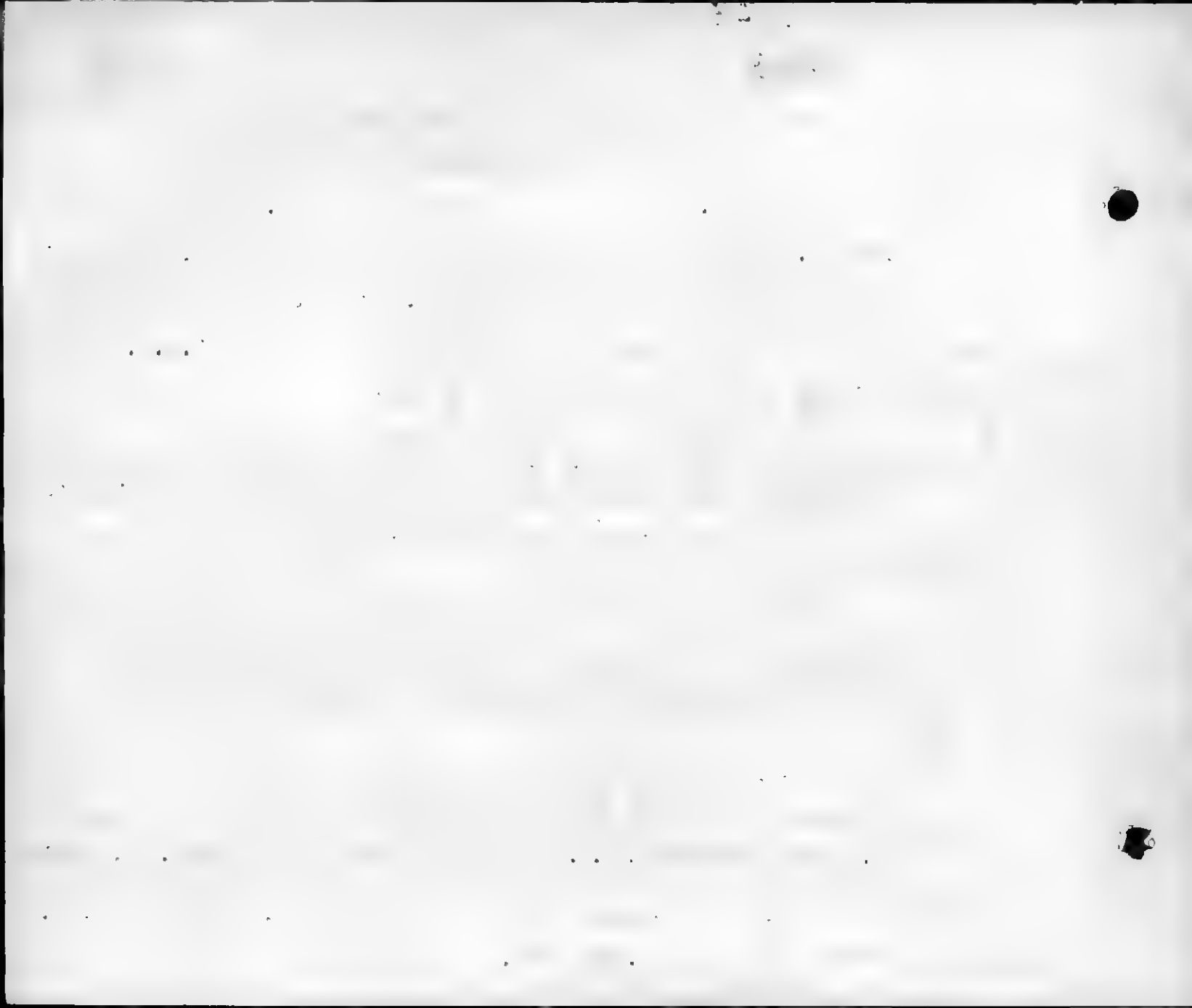
may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1444

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01425

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn</b>				c. LENGTH OF STAY IN 1b <b>X Brooklyn</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5800 Ritchie St.</b>				d. STREET ADDRESS <b>5800 Ritchie St.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Clara A. Crouch</b>				4. DATE OF DEATH <b>February 2, 1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 9, 1870</b>	
9. AGE (In years last birthday) <b>91</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Samuel Little</b>				14. MOTHER'S MAIDEN NAME <b>Julia Voyce</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Family Same</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Seriously</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) <b>Undet</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 1, 1959</b> to <b>Feb 2, 1961</b> , that (I) (we) last saw the deceased alive on <b>Jan 30 1961</b> , and that death occurred at <b>11 P M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>A. Bradley Daugharthy</b> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>2-5-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. Bradley Daugharthy, M.D.</b>				22d. ADDRESS <b>1264 Francis Avenue; Balto. 27, Maryland</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/6/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Brooklyn, Anne Arundel, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>McCully Funeral Home 130 E. Fort Ave.</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>FEB 6 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			



1  
X  
I  
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

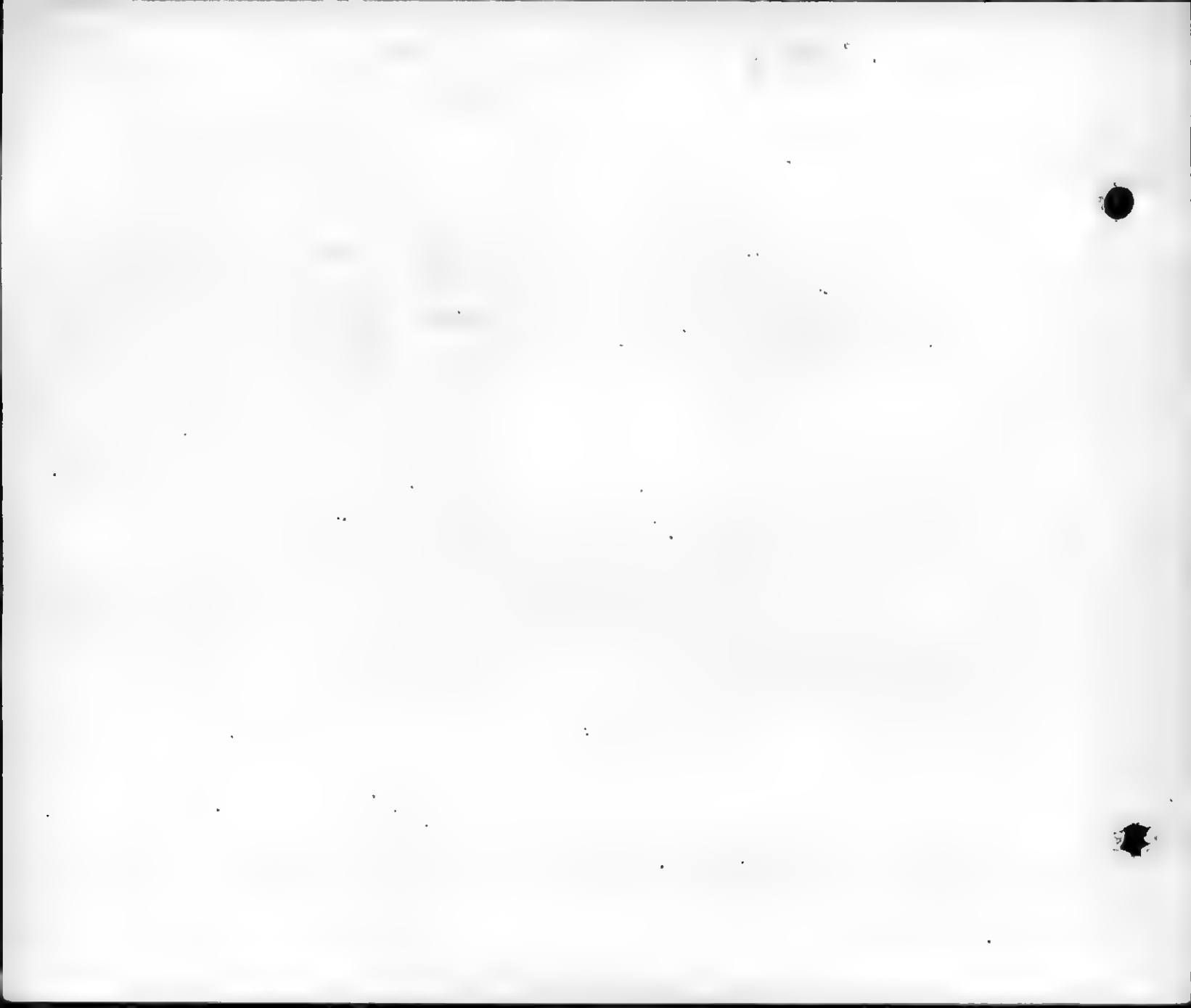
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1445

## CERTIFICATE OF DEATH

Reg. Dist. No. 01426

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>AA.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. PETERSBURG</u>		c. LENGTH OF STAY IN 1b <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John J. Cunningham</u>		4. DATE OF DEATH Month <u>3</u> Day <u>11</u> Year <u>19</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-7-90</u>
9. AGE (In years lost birthday) yrs. <u>70</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FIREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B.C.F.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <u>John</u>		14. MOTHER'S MAIDEN NAME <u>MARY J. JAMES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Family Name</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>42.005</u> DUE TO <u>Arterio-sclerotic Heart Disease</u> (b) <u>3-4 years</u> c. <u>lying cause lost.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3-4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/18</u> , 19 <u>54</u> , to <u>2/11</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>2/6</u> , 19 <u>61</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harry Seibel</u> M.D. <u>1226 Hammer St. Bldg 30 Rd</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>DR. HARRY DEIBEL</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>2</u>		22b. DATE THEREOF <u>2-15-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CATHEDRAL</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. E. F. 130 E. F. 130 E. F. 130 E. F.</u>		24a. REC'D BY REGISTRAR <u>FEB 15 '61</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	



TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

(M)

(I)

MARYLAND STATE DEPARTMENT OF HEALTH

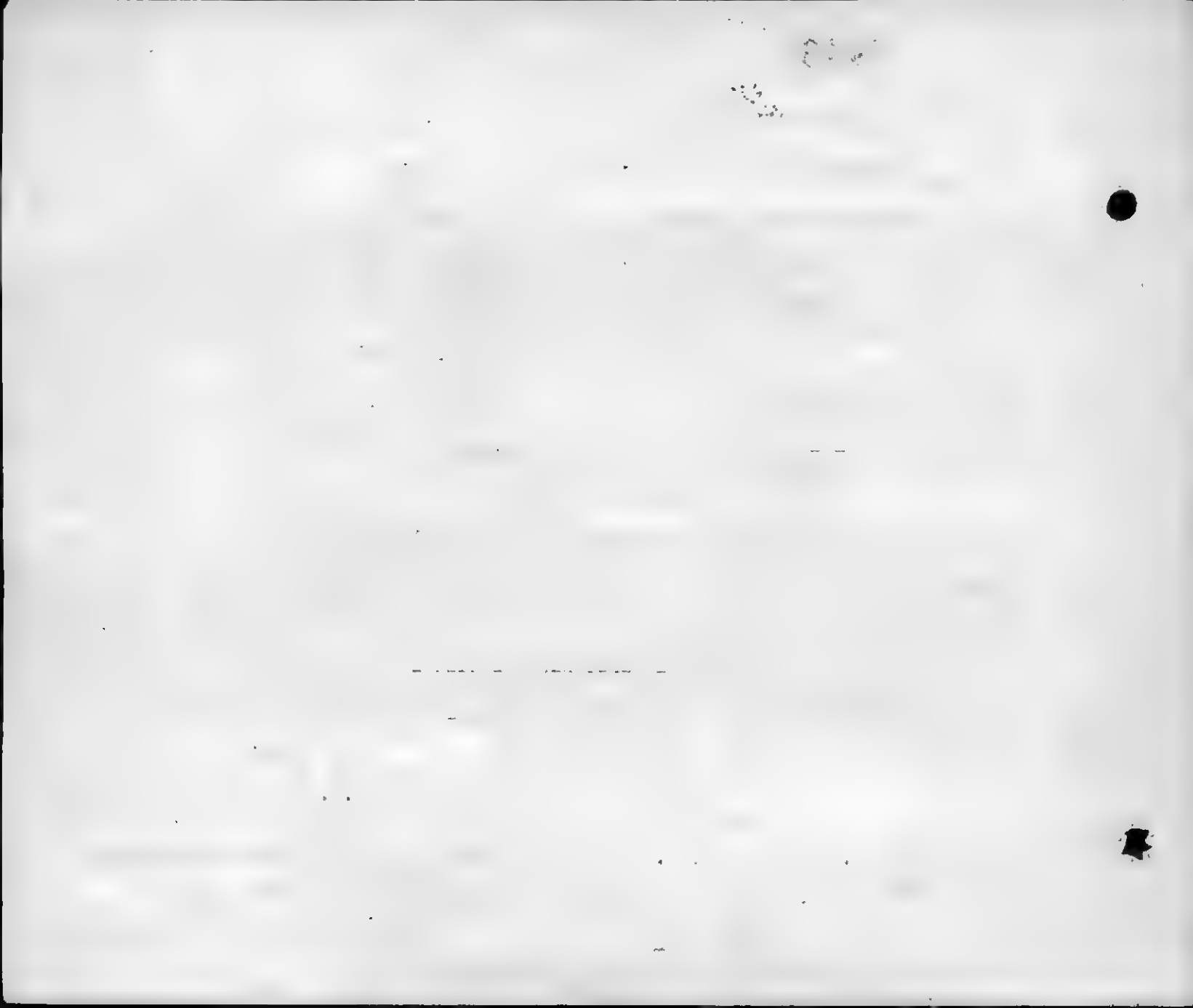
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1446

CERTIFICATE OF DEATH

01427

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY IN 1b <u>4 yrs. 29 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Crownsville State Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>402 Main Court ?</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>George</u> Middle <u>Henry</u> Last <u>Davis</u>		<b>4. DATE OF DEATH</b> Month <u>2</u> Day <u>22</u> Year <u>1961</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>Negro</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>1871</u>
<b>9. AGE</b> (In years last birthday) <u>90</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>0</u> Days <u>0</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Unknown</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>North Carolina</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>North Carolina</u>	
<b>13. FATHER'S NAME</b> <u>George Davis</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Isabella ?</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Unknown</u>		<b>16. SOCIAL SECURITY NO.</b> <u>Unknown</u>	
<b>17. INFORMANT</b> <u>Hospital Records</u>		Address _____	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 422-1 } DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Cardiovascular Disease</u> (a), stating the underlying cause last. } DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While <u>at work</u> <input checked="" type="checkbox"/> While <u>at work</u> <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f. (City or town)</b> _____ (County) _____ (State) _____	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>1/23/</u> ..... <u>19 57</u> <b>to</b> <u>2/22/</u> ..... <u>19 61</u> <b>that (I) (we) last saw the deceased alive on</b> <u>2/22/</u> ..... <u>1961</u> <b>and that death occurred at</b> <u>2:40 P.M.</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>L. Benedict, M. D.</u>		<b>22b. DATE SIGNED</b> <u>2/23/61</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>L. Benedict, M. D.</u>		<b>22d. ADDRESS</b> <u>Crownsville State Hospital, Maryland</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Buried</u>		<b>23b. DATE THEREOF</b> <u>March 1961</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Calixtus</u>		<b>23d. LOCATION</b> (City, town or county) <u>Baltimore</u> (State) <u>Md.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>[Signature]</u>		<b>25a. REC'D BY REGISTRAR</b> <u>2 MAR 2 '61</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>		<b>25c. REGISTRAR'S NAME</b> <u>Arthur L. Fraser</u>	





The funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

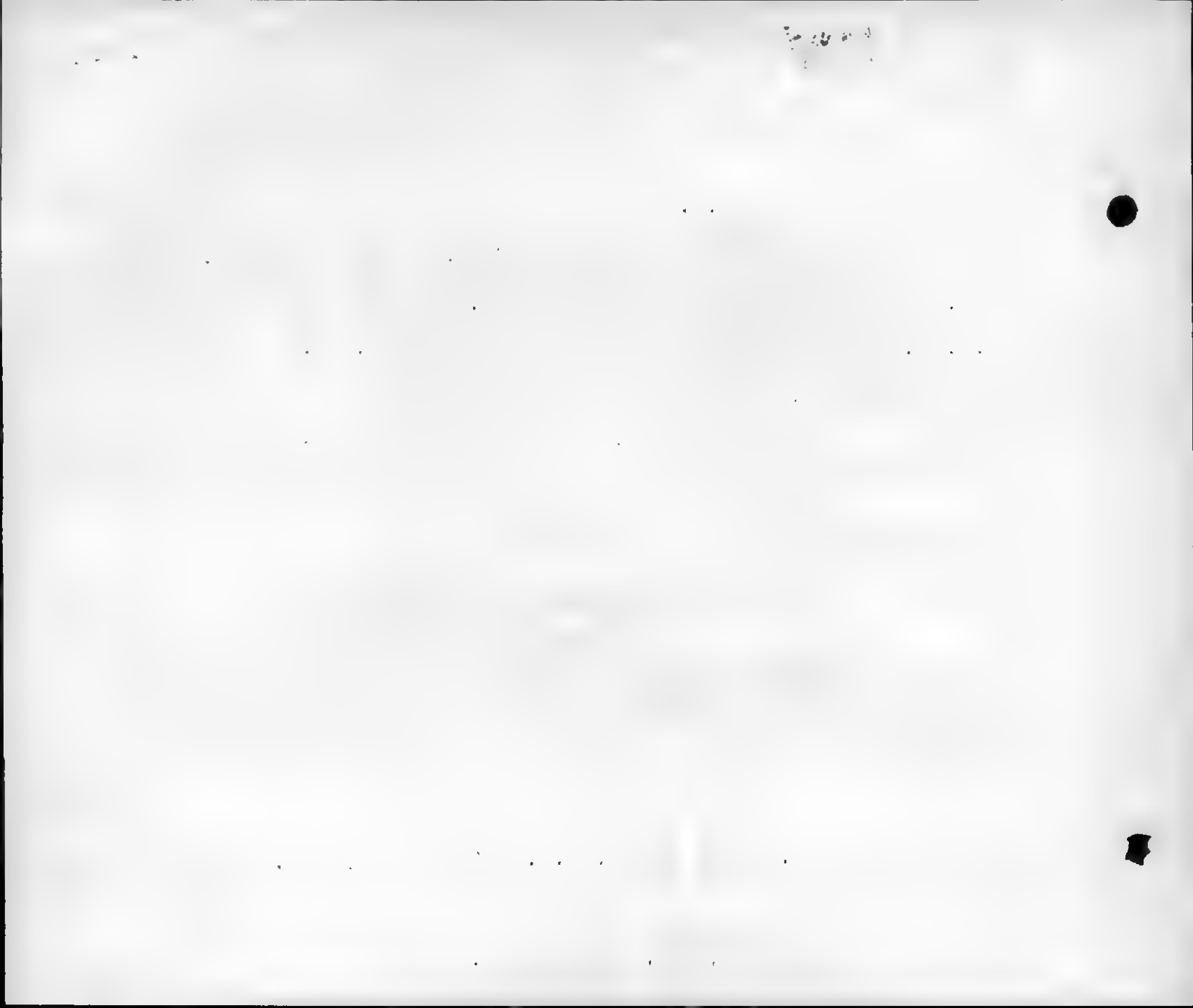
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1447

01428

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>				c. LENGTH OF STAY IN TB <b>10 days</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>				d. STREET ADDRESS <b>506 Monroe Circle</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>404 Second Avenue, S.W.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Hiram</b> Middle <b>Disney</b> Last <b>Disney</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>25</b> Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 5, 1873</b>		9. AGE (In years last birthday) yrs. <b>87</b>	10. IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b> Hours <b>2</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>A.A.Co. Roads</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>County Employee</b>		11. BIRTHPLACE (State or foreign country) <b>AA County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Wilson Disney</b>				14. MOTHER'S MAIDEN NAME <b>Angeline Ray</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>-----</b>		17. INFORMANT <b>Mrs Mamie Rurdham, same as 1</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardio-vascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio Sclerosis</b> DUE TO (c) <b>-----</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 year</b> <b>2 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>-----</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1941</b> to <b>Feb 25</b> , 1961, that (I) (we) last saw the deceased alive on <b>Jan 4</b> , 1961, and that death occurred at <b>7 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>James S. Billingslea</b>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>Feb 27 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>James S. Billingslea, M.D.</b>				22d. ADDRESS <b>108 Central Ave. NW, Glen Burnie, Md.</b>			
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2/28/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Memorial</b>		23d. LOCATION (City, town, or county) (State) <b>Elkridge Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping and Kirkley</b>				25a. REC'D BY REGISTRAR <b>DATE MAR 2 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

MEDICAL CERTIFICATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01429

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>D. C.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Deale</i>		c. LENGTH OF STAY IN 1b <i>Lifetime</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Deale, Md. Near Churchtown</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <i>Deale Beach Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>James</i> Middle <i>Alton</i> Last <i>Dorsey</i>				4. DATE OF DEATH Month <i>February</i> Day <i>2</i> Year <i>1961</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>12/8/1903</i>		9. AGE (In years last b. rthday) <i>57</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Accountant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>BANK</i>		11. BIRTHPLACE (State or foreign country) <i>Churchtown, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Charles William Dorsey</i>				14. MOTHER'S MARRIAGE NAME <i>Mary Elizabeth Franklin</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>212-09-0443</i>		17. INFORMANT Name <i>MARY E. FRANKLIN</i> Address <i>Churchtown, Md</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <i>Coronary artery disease &amp; bronchial asthma</i> DUE TO (c) <i>Alcoholism</i>						INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i> <i>years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Willard F. Smith</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>WILLARD F. SMITH, MD</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>FEB 6, 1961</i>		22c. NAME OF CEMETERY OR CREMATORY <i>BALTIMORE NATIONAL</i>		22d. LOCATION (City, town, or county) (State) <i>BALTIMORE MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J A Hardesty + Son</i>				ADDRESS <i>Galesville Md</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 7 '61</i>	
				24b. REGISTRAR'S SIGNATURE <i>Wm L. Tinsley</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

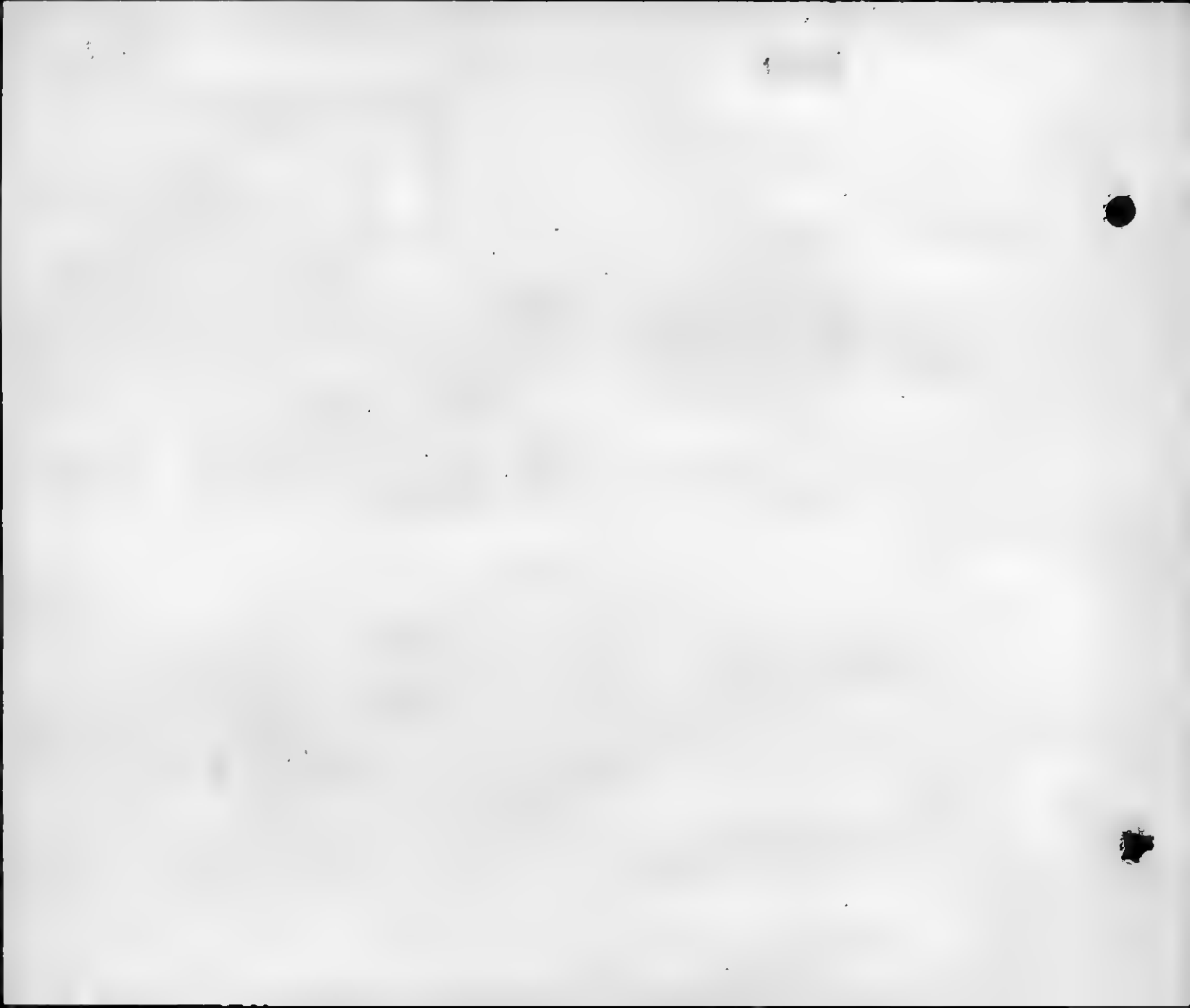
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1450

## CERTIFICATE OF DEATH

01430

<b>1. PLACE OF DEATH</b> a. COUNTY <u>AA</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>AA General</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>AA</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u> d. STREET ADDRESS <u>Rt 2 Box 622</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Emma C. Drews</u>		<b>4. DATE OF DEATH</b> <u>Feb 1 - 4 1961</u>		<b>9. AGE (In years last birthday)</b> <u>86</u>	
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Home</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Wisconsin</u>	
<b>13. FATHER'S NAME</b> <u>Fred Schanke</u>		<b>14. MOTHER'S M maiden NAME</b> <u>Louisa Hook</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO</b>		<b>17. INFORMATION</b> <u>Mrs John H. Armiger Jr.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (b) <u>1/24</u> (a), stating the underlying cause last. (c) <u>1961</u> DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b>		<b>20g. (County)</b>		<b>20h. (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>1/24</u> <u>1961</u> <u>8:30</u> <u>A.M.</u> <b>to</b> <u>2/4</u> <u>1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>1/24</u> <u>1961</u> ; <b>and that death occurred</b> <u>2/4</u> <u>1961</u> <u>8:30</u> <u>A.M.</u> <b>from the causes and on the date stated above.</b>					
<b>22a. SIGNATURE</b> <u>Gerard Church</u>		<b>22b. DATE SIGNED</b> <u>2/5/61</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>GERARD CHURCH</u>	
<b>22d. ADDRESS</b> <u>121 CATHEDRAL ST. ANNAPOLIS</u>		<b>22e. ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>2-8-1961</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Wisconsin Memorial</u>	
<b>23d. LOCATION (City, town or county)</b> <u>Milwaukee</u>		<b>23e. (State)</b> <u>Wis.</u>		<b>23f. (Country)</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John M. Taylor Sons</u>		<b>24a. ADDRESS</b> <u>Annapolis Md.</u>		<b>24b. REC'D BY REGISTRAR</b> <u>FEB 7 '61</u>	
<b>24c. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hume</u>		<b>24d. DATE</b>			



1451

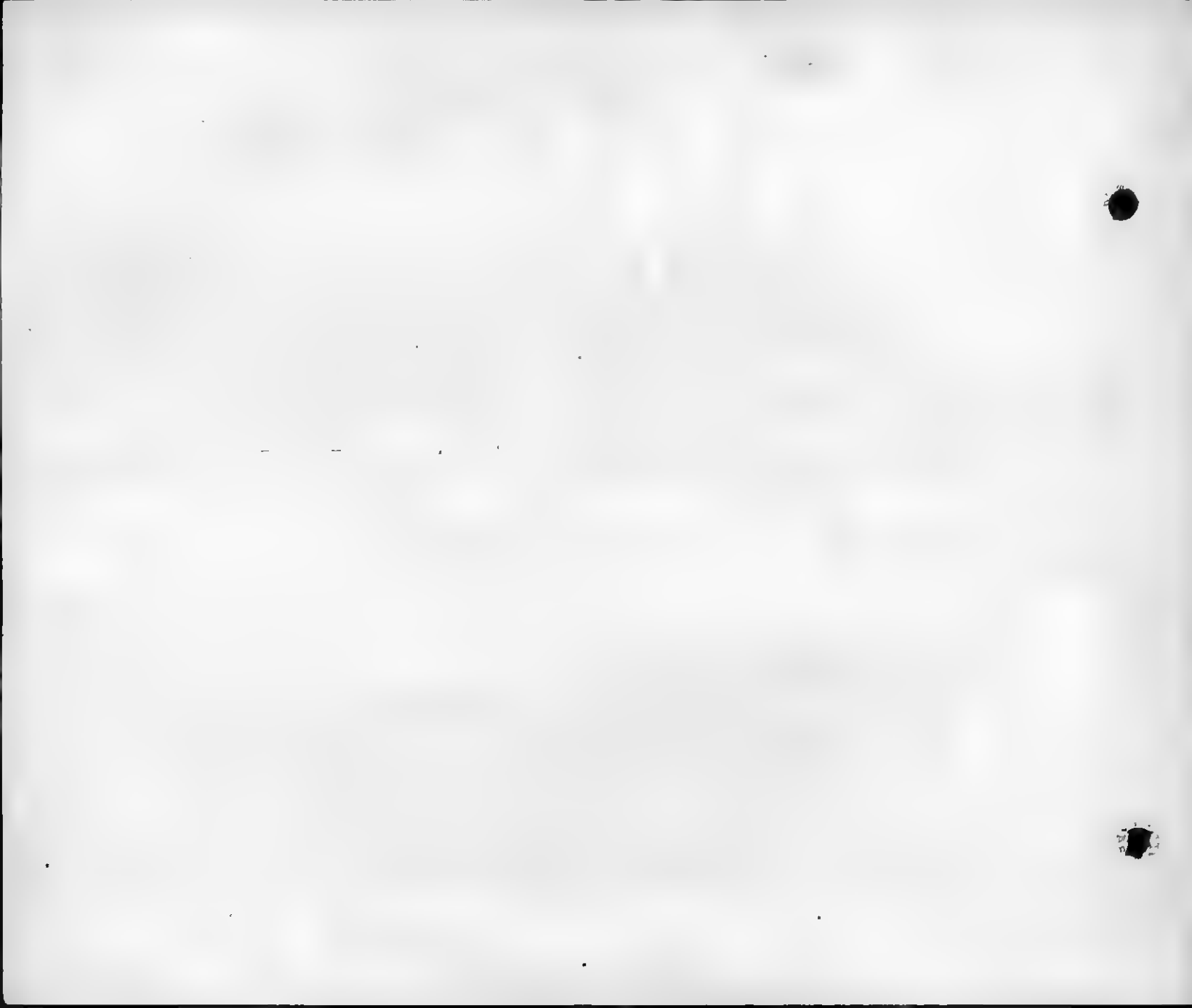
CERTIFICATE OF DEATH

Reg. Dist. No.

01431

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>10</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1161 Eastport Terrace</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
f. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1161 Eastport Terrace</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>RYLAND</u> Last <u>DUNAWAY</u>		4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>25</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 18, 1878</u>
9. AGE (In years last birthday) <u>82</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>2</u> Days <u>24</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Const.</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Rolston Dunaway</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>220-05-0563</u>	
17. INFORMANT <u>Mrs Helen M Dunaway- Wife- Same as # 2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular insufficiency</u>			
450.0 DUE TO (b) <u>Arteriosclerotic vascular disease</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/20</u> , 19 <u>61</u> , to <u>2/23</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>2/23</u> , 19 <u>61</u> , and that death occurred at <u>4 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard I. Hochman</u> M D		DATE SIGNED <u>2/24/61</u>	
PHYSICIAN'S NAME (Type) <u>Richard I Hochman MD</u>		<u>100 Cathedral Street, Annapolis, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 27, 61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>FEB 28 1961</u>		24b. REGISTRAR'S SIGNATURE <u>Robert S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

13  
M  
X  
I

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01432

1452

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Severna Park c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rt. 1 Box 345 Severna Park, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY A.A.Co. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park d. STREET ADDRESS Rt. 1 Box 345 Severna Park	
3. NAME OF DECEASED (Type or print) Naomi Marie Dunn 4. DATE OF DEATH February 20th 1961		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 20, 1886 9. AGE (in years last birthday) 74 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper 10b. KIND OF BUSINESS OR INDUSTRY Balto., Md.		11. BIRTHPLACE (County & State, or foreign country) U.S.A. 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph L. Dunn 14. MOTHER'S MAIDEN NAME Annie Kehoe		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT Mary E. Dunn Rt. 1 Box 345 Severna Park	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 350X Acute respiratory (Tracheal) obstruction Parkinson's Disease 3 years DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 1960 to February 1961 that (I) (we) last saw the deceased alive on Feb. 16, 1961, and that death occurred at 3 P.M. from the causes and on the date stated above. 22a. SIGNATURE Francis I. Codd M.D. 22b. DATE SIGNED 2-21-61 22c. PHYSICIAN'S NAME (Type) Francis I. Codd M.D. 22d. ADDRESS Severna Park, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 2/23/61 23c. NAME OF CEMETERY OR CREMATORY New Cathedral 23d. LOCATION (City, town or county) (State) Baltimore Maryland		25a. REC'D BY REGISTRAR DATE FEB 23 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Road			

1914



TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

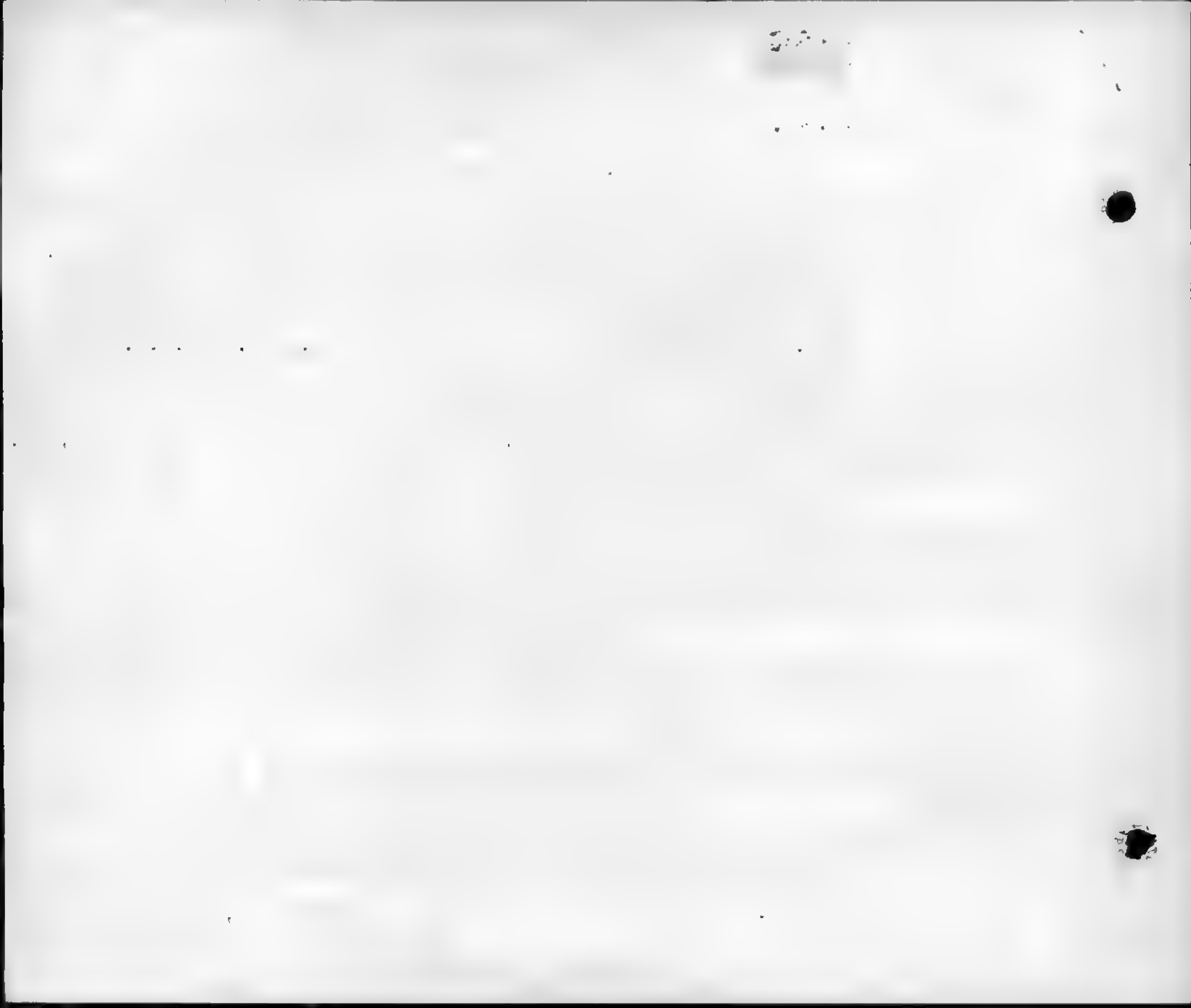
VR A15 (4)  
ISM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
1453  
CERTIFICATE OF DEATH

01453

1. PLACE OF DEATH a. COUNTY Anne Arundel				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland				b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn				c. LENGTH OF STAY IN 1b 52 yrs.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn			
d. NAME OF HOSPITAL (If not in hospital, give street address) Camp Meade Road				d. STREET ADDRESS Camp Meade Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WESLEY DURNER				4. DATE OF DEATH Month Day Year February 12th 1961							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4th February 1878		9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith (ret.)				10b. KIND OF BUSINESS OR INDUSTRY Self-Employed		11. BIRTHPLACE (State or foreign country) Anne Arundel Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Samuel Durner				14. MOTHER'S MAIDEN NAME Mary Watts							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. May Disney (daughter) Glen Burnie, Md.				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1.1 DUE TO (b) 422.1.1 DUE TO (c) 422.1.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								INTERVAL BETWEEN ONSET AND DEATH 10 1/2			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1950, to Feb. 12, 1961, that (I) (we) last saw the deceased alive on 3/12, 1961, and that death occurred at 10 P. M. from the causes and on the date stated above.											
22a. SIGNATURE Chas. L. Brock Jr.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2-12-61	
22c. PHYSICIAN'S NAME (Type) Richard P. Brock Jr.				22d. ADDRESS Glen Burnie, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 16th Feb. '61		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		23d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE Richard P. Brock Jr.				ADDRESS Glen Burnie, Maryland		25a. REC'D BY REGISTRAR DATE FEB 16 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Krous			

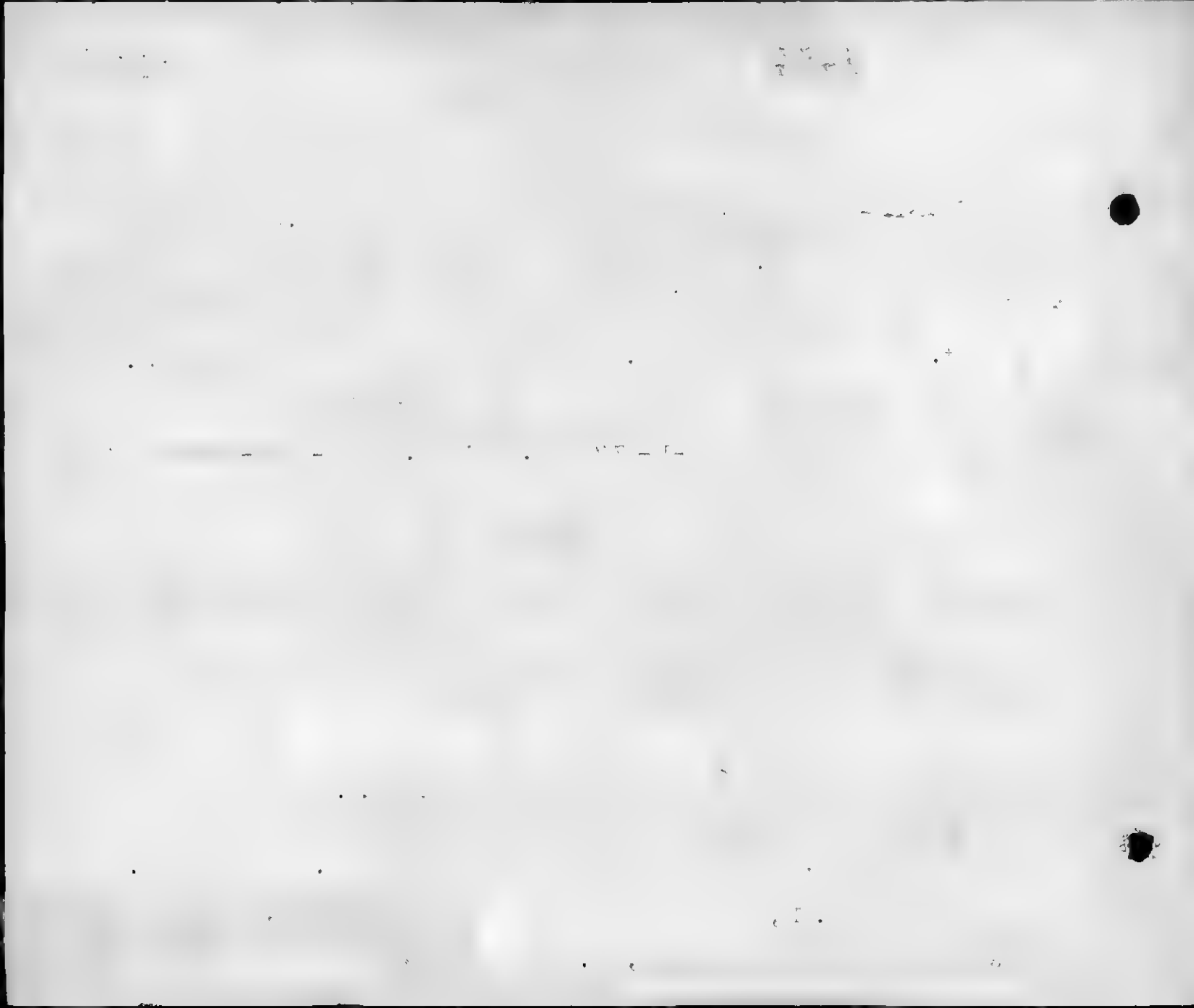


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN b. <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u> (Dead on arrival)		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>9 Steele Ave.,</u>	
3. NAME OF DECEASED (Type or print) <u>E. Saunders</u> <b>First</b> <u>DUVALL</u> <b>Middle</b> <u>DUVALL</u> <b>Last</b>		4. DATE OF DEATH <u>February 11 19 61</u> <b>Month</b> <b>Day</b> <b>Year</b>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 15, 1901</u> <b>9. AGE (in years last birthday)</b> <u>59 yrs.</u> <b>IF UNDER 1 YEAR</b> <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U S Gov.</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Ringgold Duvall</u>		14. MOTHER'S MAIDEN NAME <u>Mary Willard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-16-0774</u>	
17. INFORMANT <u>Mrs. Cecile K. Duvall- Wife- same as # 2</u>		Address <u></u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Caducous aneurysm</u> 416X DUE TO (b) <u>Rheumatic heart disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>instant</u> <u>20 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY <u>11:50 P.M.</u> <b>Hour</b> <b>a.m.</b> <b>p.m.</b>	20d. INJURY OCCURRED <u>While at work</u> <b>While at work</b> <input type="checkbox"/> <b>Not While at work</b> <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) <u>Annapolis</u> (County) <u>Md.</u> (State) <u></u>
21. I certify that (I) <u>John L. Hedeman</u> attended the deceased from <u>July 1955</u> to <u>February 1961</u> , that (I) <u>see</u> last saw the deceased alive on <u>Feb. 10 1961</u> , and that death occurred at <u>11:50 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>John L. Hedeman</u>		22b. DATE SIGNED <u>2/13/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>John L. Hedeman</u>		22d. ADDRESS <u>121 Cathedral St., Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 14, 61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Salem Cemetery</u>
23d. LOCATION (City, town or county) <u>Annapolis, Maryland</u>		(State) <u></u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>		25a. REC'D BY REGISTRAR <u>15 '61</u>	
ADDRESS <u>Annapolis, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>	

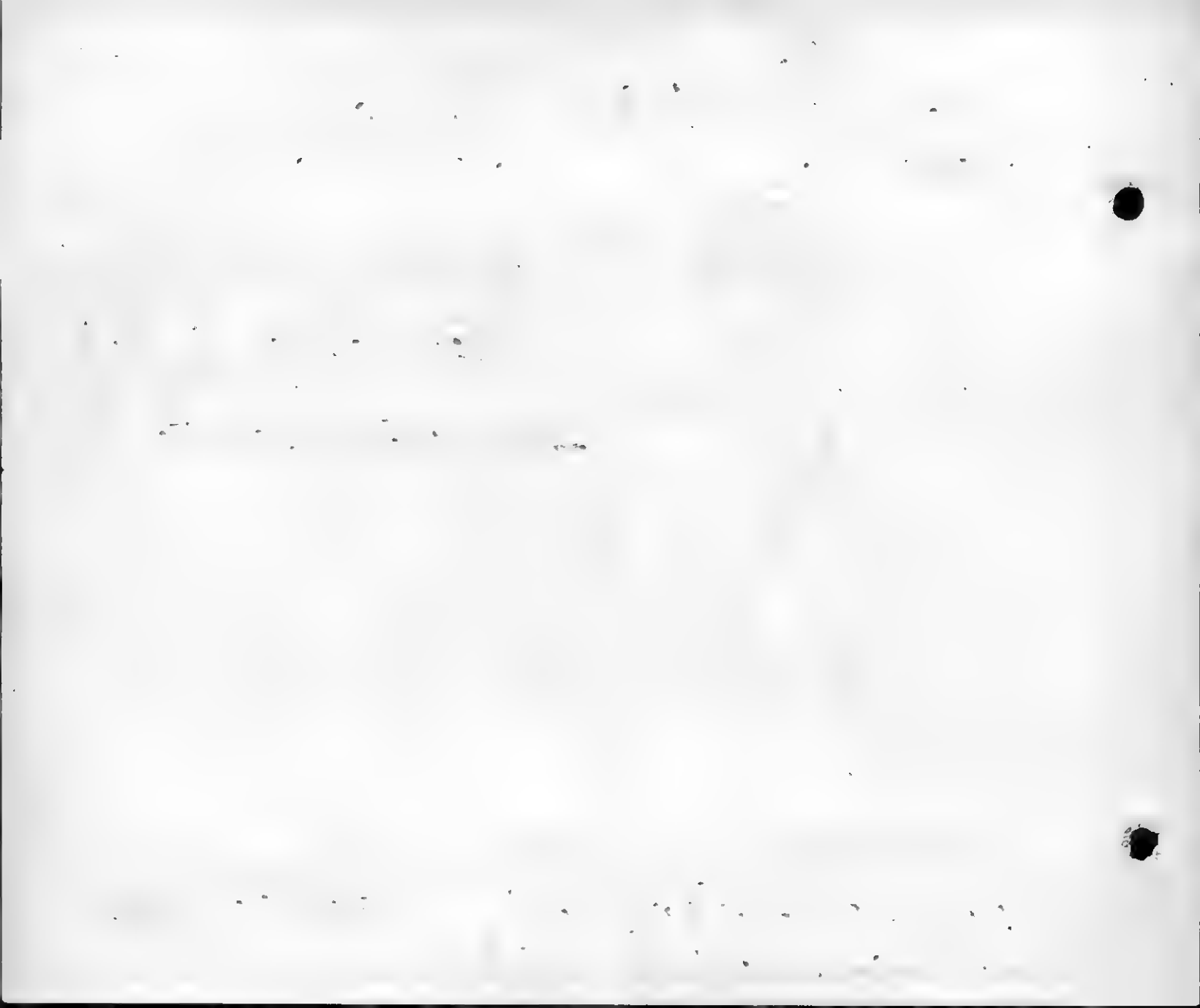


1455

CERTIFICATE OF DEATH

Reg. Dist. **N01455**

1. PLACE OF DEATH a. COUNTY <b>Chesapeake A.A. MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sandyville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sandyville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) First <b>Lynn</b> Middle <b>Edie</b> Last <b>Emanuel</b>		4. DATE OF DEATH Month <b>2</b> Day <b>12</b> Year <b>1961</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>B.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 31/60</b>
9. AGE (In years lost birthday) <b>1</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Henry Emanuel</b>		14. MOTHER'S MAIDEN NAME <b>Sidney Ann Edwards</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Sidney C. Edwards Odenton Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: <b>491X</b> DUE TO <b>acute bronchopneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 9</b> , 19 <b>61</b> , to <b>Feb 12</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>Feb 9</b> , 19 <b>61</b> , and that death occurred at <b>8:30 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Joseph Lipsky</b> M.D.		DATE SIGNED <b>2/12/61</b>	
PHYSICIAN'S NAME (Type) <b>JOSEPH LIPSKEY</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial 2-14-1961</b>		22b. DATE THEREOF <b>2-14-1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Spethedonia</b>		22d. LOCATION (City, town or county) (State) <b>Odenton Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Reese</b> ADDRESS <b>Arna</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 15 '61</b>	
		24b. REGISTRAR'S SIGNATURE <b>C. S. S. K. S. S.</b>	





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

1456

01436

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ft Geo G. Meade</b>		c. LENGTH OF STAY IN 1b <b>4 yrs.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort George G. Meade</b>		d. STREET ADDRESS <b>1 1239-A</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>ELIZABETH</b>		Middle <b>ANN</b>		Last <b>ENDERS</b>		4. DATE OF DEATH Month <b>FEBRUARY</b>		Day <b>13</b>		Year <b>19 61</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Cau</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 16, 1879</b>		9. AGE (In years last birthday) <b>81</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Samuel Crump</b>						14. MOTHER'S MAIDEN NAME <b>Ann Riker</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Husband</b>				Address <b>Quarters # 1239-A Ft Geo G. Meade, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Emaciation</b> <b>195.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO												INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (the medical examiner) examined the deceased <b>examined</b> <b>13 Feb 19 61</b> and that death occurred at <b>8:00 AM</b> from the causes and on the date stated above.													
22a. SIGNATURE <b>Nathaniel S. Beard</b>						M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE <b>13 Feb 61</b>		SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>NATHANIEL S. BEARD, Capt., M.C.</b>						22d. ADDRESS <b>US Army Hosp Ft Geo G. Meade, Md.</b>							
23a. BURIAL, CREMATION (Specify) <b>Cremation</b>				23b. DATE THEREOF <b>2-14-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Crematory</b>				23d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Ware</b>						ADDRESS <b>Glen Burnie, Md</b>		25a. REC'D BY REGISTRAR <b>FEB 15 '61</b>		25b. REGISTRAR'S SIGNATURE <b>S. Trans</b>			

MEDICAL CERTIFICATION

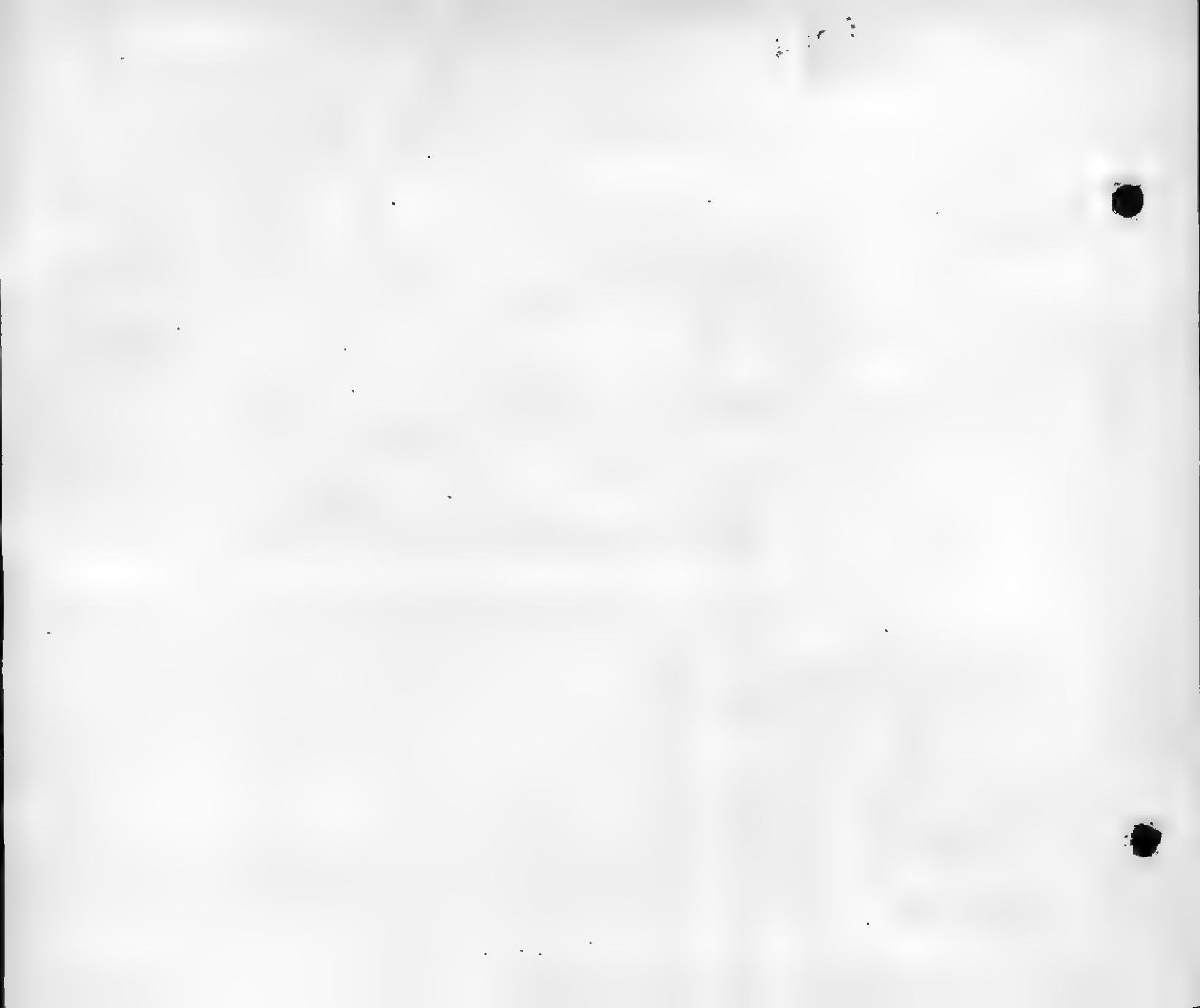


**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

1457

01457

1. PLACE OF DEATH a. COUNTY <i>A. A.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>A. A.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis MD</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>426 Third St</i>				d. STREET ADDRESS <i>1426 Third St</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>Elsie M. Engelke</i>				4. DATE OF DEATH Month <i>2</i> - Day <i>8</i> Year <i>1961</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Apr 17<sup>th</sup> 1875</i>	
9. AGE (In years last birthday) <i>85</i> yrs.		IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>		IF UNDER 24 HRS. Hours <i>0</i> Min <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Annapolis</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>William Harrison</i>				14. MOTHER'S MAIDEN NAME <i>Dora Woolford</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Mrs Ethel M. Schultz</i> Address <i>(2)</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ischaemic Heart Disease</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Senility</i>							INTERVAL BETWEEN ONSET AND DEATH <i>Several yrs.</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>(the hospital)</del> attended the deceased from <i>2-8-</i> <i>1961</i> , to <i>2-8-</i> <i>1961</i> , that (I) <del>last</del> saw the deceased alive on <i>2-8-</i> <i>1961</i> , and that death occurred at <i>7:45</i> AM, from the causes and on the date stated above.							
22a. SIGNATURE <i>Mr. P. Stephens</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>2/8/61</i>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>2-10-1961</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore National</i>		23d. LOCATION (City, town, or county) (State) <i>Baltimore MD</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Sayla Sons</i>				25a. REC'D BY REGISTRAR DATE <i>FEB 14 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>	



# 1458 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

Reg. Dist. No. 01438

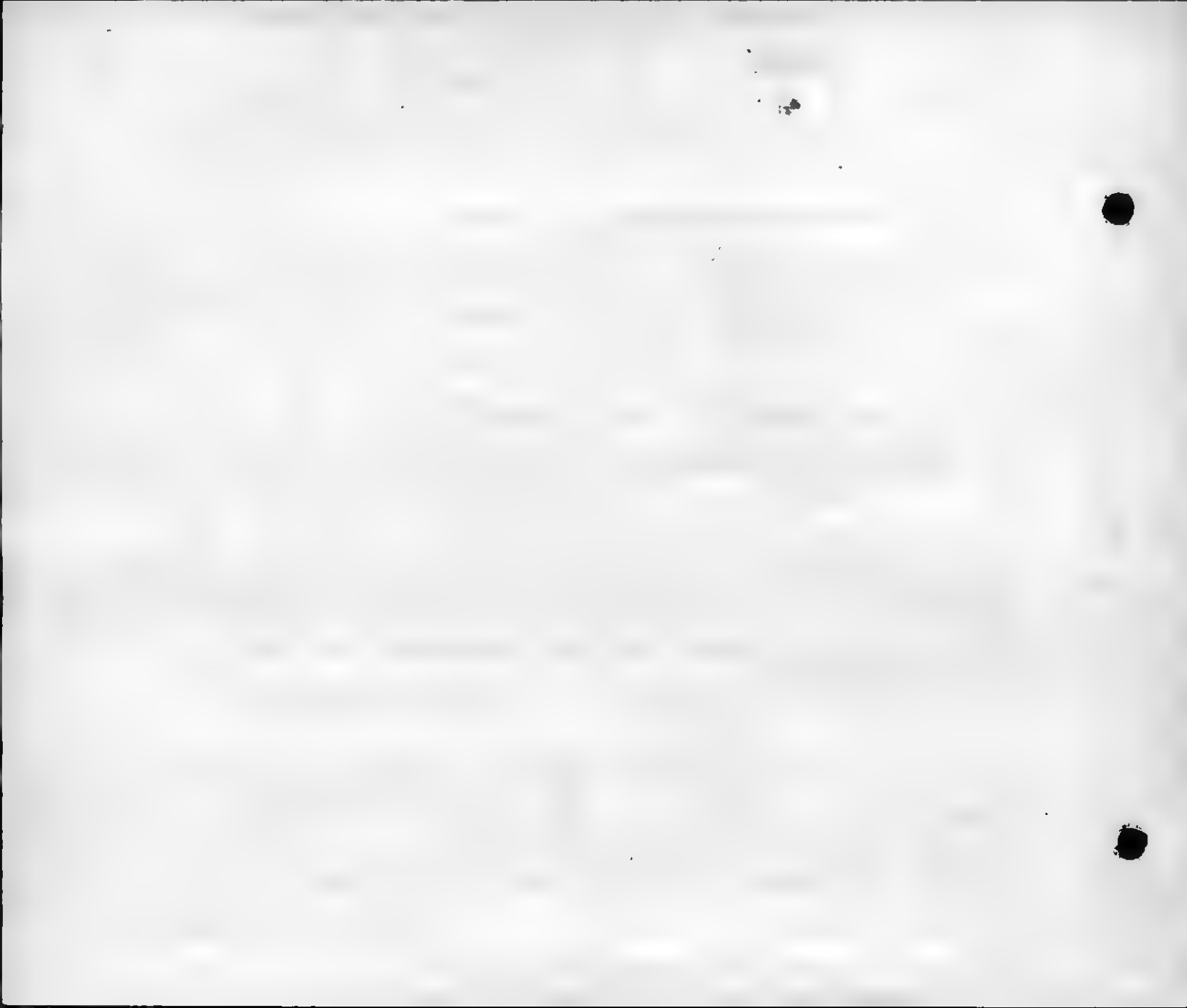
1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Annapolis, Maryland				d STREET ADDRESS 196 DUKE OF GLOUCESTER STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM KEITH ENRIGHT				4. DATE OF DEATH Month Day Year FEBRUARY 27 19 61			
5. SEX MALE		6. COLOR OR RACE CAUC.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10 FEBRUARY 1909	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICER USMC				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) COLORADO	
12. CITIZEN OF WHAT COUNTRY? UNITED STATES							
13. FATHER'S NAME JOHN ALBERT ENRIGHT				14. MOTHER'S MAIDEN NAME ROSE AGNES BENSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES 1930-1959				16. SOCIAL SECURITY NO. 216-38-5087		17. INFORMANT (Wife) DOLORES F. ENRIGHT ST., ANNAPOLIS, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLISM 465X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 42 Hours
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 10 January, 1961, to 27 February, 1961, that I last saw the deceased alive on 27 February, 1961, and that death occurred at 3:23A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE [Signature] M.D.							
PHYSICIAN'S NAME (Type) Robert D. BELSKY, LT MC USNR				U. S. Naval Hospital, Annapolis, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar 1 1961		22c. NAME OF CEMETERY OR CREMATORY Naval Academy		22d. LOCATION (City, town, or county) (State) Annapolis Md	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Saylor Sons				ADDRESS Annapolis Md.		24a. REC'D BY REGISTRAR DATE MAR 1 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Frank			



# 1 1459 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Item 1 Will-2002-2-21-1 et CERTIFICATE OF DEATH Reg. Dist. No. 01439

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>York</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u>		c. LENGTH OF STAY IN 1b <u>2 month</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>"Private home"</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Evelyn</u> First <u>FABIE</u> Last		4. DATE OF DEATH Month <u>Feb</u> Day <u>8</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 11, 1911</u>
9. AGE (In years lost birthday) <u>49</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas Wehn</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Butcher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mr. Aloysius Fabie. (same)</u>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS GENERAL</u> DUE TO <u>CARCINOMA of Cervix Uteri</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 12, 1960</u> to <u>Feb 8, 1961</u> , that I last saw the deceased alive on <u>Jan 27, 1961</u> , and that death occurred at <u>6 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph Taler, M.D.</u>		ADDRESS (Street, city or town, state) <u>102 B &amp; A Blvd. N.E.</u> DATE SIGNED <u>2-8-61</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH TALER, M.D.</u>		<u>GLEN BURNIE, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-11-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Ritchie Hwy. A.A. Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Gance</u> ADDRESS <u>4001 Ritchie Hwy.</u>		24a. REC'D BY REGISTRAR <u>DATE FEB 16 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Orlando S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.





## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundle</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institutional Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Ann Arundle</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Deale</b>		c. LENGTH OF STAY IN 1b <b>12 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Residence Box 465 Route #1</b>		d. STREET ADDRESS <b>Route #1, Box 465</b>	
3. NAME OF DECEASED (Type or print) <b>Howard</b> <b>FRANCIS</b> <b>Fearson Jr.</b>		4. DATE OF DEATH Month <b>February</b> Day <b>10</b> Year <b>1961</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 7, 1899</b>
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during kind of working life, even if retired) <b>Bricklayer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Howard Francis Fearson</b>		14. MOTHER'S MAIDEN NAME <b>Emma L. Mills</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>5790 34066</b>	
17. INFORMANT <b>Mrs. Hazel S. Fearson, Route #1, Box 465, Deale, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> 42- DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> years			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Congestive heart failure</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan.</b> 19 <b>60</b> , to <b>Feb 10</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>Jan 30</b> , 19 <b>61</b> , and that death occurred at <b>7 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Shady side, Md.</b> DATE SIGNED <b>2/10/61</b>			
ACTUAL SIGNATURE <b>Willard F. Smith</b> M.D.		PHYSICIAN'S NAME (Type) <b>WILLARD F. SMITH</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 14, 1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. CHAMBERS CO.,</b>		ADDRESS <b>Riverdale, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>FEB 14 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 may be retained by the hospital or attending physician.

Page 1 of 2

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the funeral director. Pages 1 and 2 should be filed with the funeral director.

1  
1  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1461

CERTIFICATE OF DEATH

01441

1 PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY in 1b <b>10 years</b> <b>8 mos. 23 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>(A)E.</b> Last <b>Franklin</b>		4. DATE OF DEATH Month <b>2</b> Day <b>5</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 14, 1886</b>
9 AGE (In years, month, day) <b>74</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jerry?</b>		14. MOTHER'S MAIDEN NAME <b>Martha ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17 INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> 7-2-2-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome associated with Generalized Arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) _____	
20c. TIME OF INJURY Month, Day, Year <b>House</b> 19 p. m.		20d. INJURY OCCURRED <b>While working</b> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, school, office bldg., etc.) <b>Factory</b>		20f. (City or town) (County) (State) _____	
21 I certify that (I) (this hospital) attended the deceased from <b>5/12/61</b> to <b>2/5/61</b> , that (I) (we) last saw the deceased alive on <b>2/5/61</b> , and that death occurred at <b>3:15 AM</b> from the causes and on the date stated above			
22a. SIGNATURE <b>L. Benedict, M.D.</b>		22b. DATE SIGNED <b>February 6, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M.D.</b>		22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2/11/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Park</b>	23d. LOCATION (City, town, or county) (State) <b>Baltimore City, Maryland</b>
24 FUNERAL DIRECTOR'S SIGNATURE <b>John S. ...</b>		25a. REG'D BY REGISTRAR <b>FEB 14 '61</b>	
ADDRESS <b>115 Dr. ...</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. ...</b>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

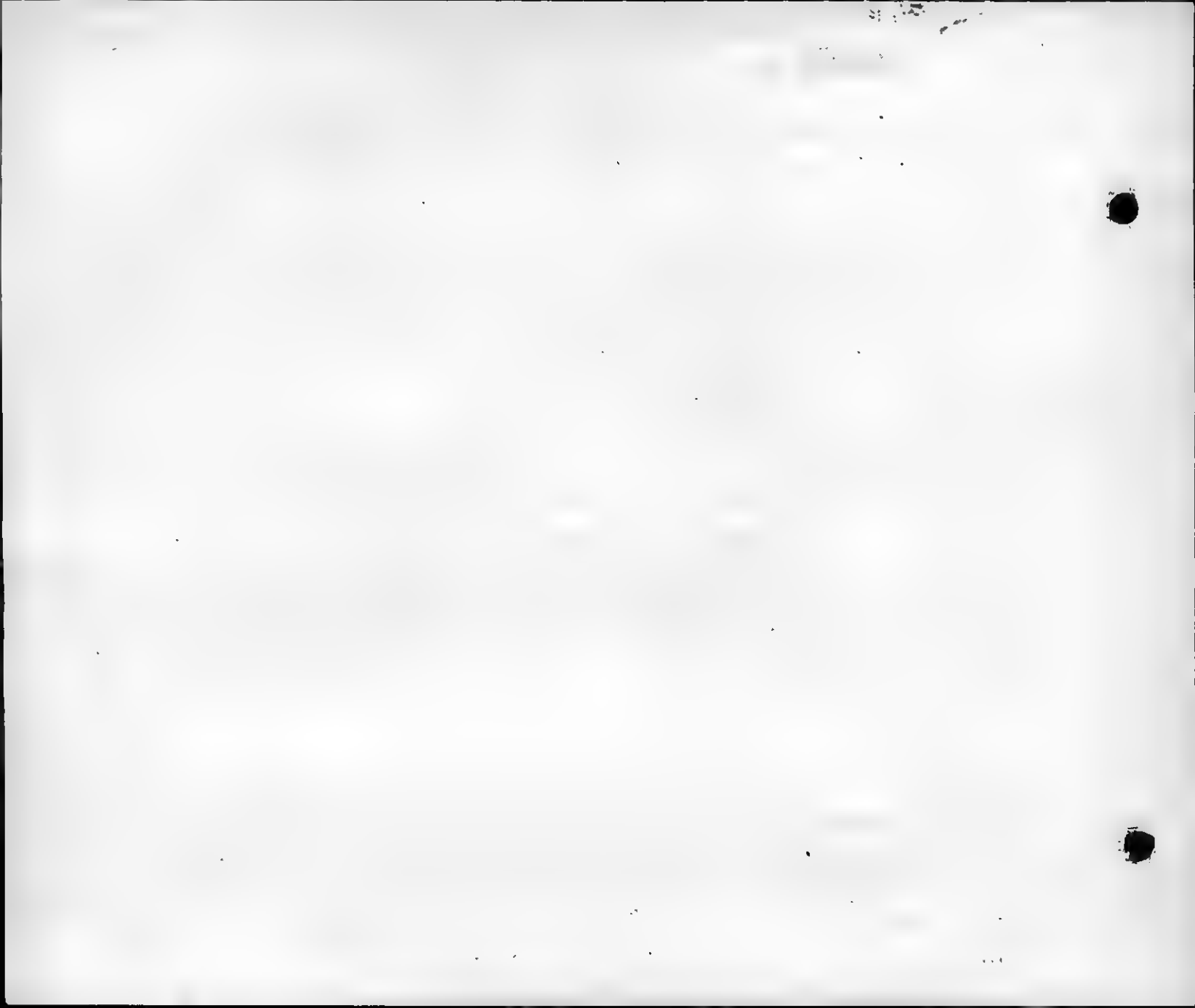
1462 Item 2

**CERTIFICATE OF DEATH**

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01442

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CROWNSTOWN</b>		c. LENGTH OF STAY IN 1b <b>only 8/27/60</b>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <b>CROWNSTOWN STATE HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAUREL</b>	
3. NAME OF DECEASED (Type or print) <b>ABRAHAM</b> First <b>GATHER</b> Middle <b>GAITHER</b> Last		4. DATE OF DEATH Month <b>2</b> Day <b>10</b> Year <b>1961</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/15/1858</b>
9. AGE (In years last birthday) <b>12</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PLASTERER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>UNKNOWN</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>THOMAS GAITHER</b>		14. MOTHER'S MAIDEN NAME <b>ELLA</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (c) <b>CHRONIC BRAIN SYNDROME ASS. C. CEREBRAL ARTERIOSCLEROSIS</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8/27/60</b> 19 <b>61</b> to <b>2/10/61</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>2/10/61</b> 19 <b>61</b> , and that death occurred at <b>9:00</b> M., from the causes and on the date stated above			
22a. SIGNATURE <b>[Signature]</b> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>L. BENEDICT M.D.</b>		22d. ADDRESS <b>CROWNSTOWN STATE HOSPITAL</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/14/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cashbury</b>		23d. LOCATION (City, town, or county) (State) <b>Howard Co. near Seabright</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>RIDGLEY-SELBY</b>		25a. REC'D BY REGISTRAR <b>FEB 16 '61</b>	
ADDRESS <b>LAUREL-MD</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1463  
CERTIFICATE OF DEATH

Reg. Dist. No.

01443

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> 'MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A-A</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park md 30 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ellerslie Rd</u>		d. STREET ADDRESS <u>Ellerslie Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Agota</u> First <u>Goldweiss</u> Middle <u>Goldweiss</u> Last <u>Goldweiss</u>		4. DATE OF DEATH <u>2-20-61</u> Month <u>2</u> Day <u>20</u> Year <u>19</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 18, 1891</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Antonius Berkoskis</u>		14. MOTHER'S MAIDEN NAME <u>Maue</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>  </u>	
17. INFORMANT <u>Family</u>		Address <u>Severna</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized metastases</u>			
174X DUE TO (b) <u>Carcinoma of uterus</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1960</u> , 19 <u>  </u> to <u>1961</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>2-19-61</u> , 19 <u>  </u> , and that death occurred at <u>11:45</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D.		ADDRESS (Street, city or town, State) <u>Severna Park md 2-20-61</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>		DATE SIGNED <u>2-20-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-24-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u>		22d. LOCATION (City, town, or County) (State) <u>Glen Burnie Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert S. Baranco-Severna Park</u>		ADDRESS <u>Md.</u>	
24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	
DATE <u>FEB 24 '61</u>			

1  
3  
M  
I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any person is deceased, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

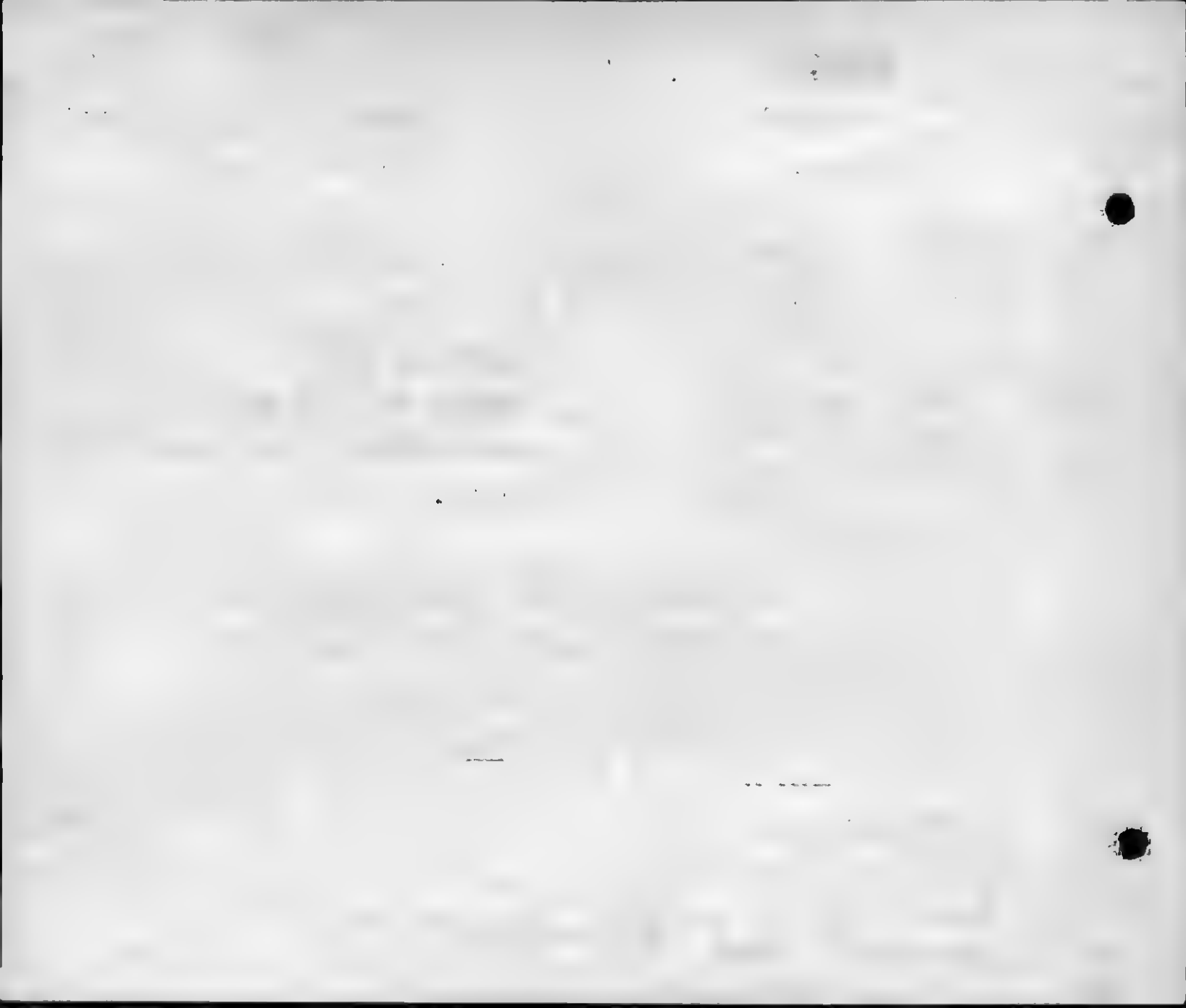
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 1464 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01444

<p>1. PLACE OF DEATH e. COUNTY <b>Anne Arundel</b> MARYLAND</p>				<p>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> ✓</p>			
<p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Shadyside</b></p>				<p>c. LENGTH OF STAY IN 1b <b>Churchton</b></p>			
<p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)</p>				<p>e. STREET ADDRESS</p>			
<p>3. NAME OF DECEASED (Type or print) <b>ROWEL CORDELL GRAY</b></p>		<p>4. DATE OF DEATH <b>February 6 19 61</b></p>		<p>5. SEX <b>Male</b></p>		<p>6. COLOR OR RACE <b>Colored</b></p>	
<p>7. MARIED <input type="checkbox"/> NEVER MARIED <input checked="" type="checkbox"/></p>		<p>8. DATE OF BIRTH <b>Dec 6 1960</b></p>		<p>9. AGE (In years last birthday) <b>2</b> yrs. Months Days</p>		<p>IF UNDER 1 YEAR IF UNDER 24 HRS</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>		<p>10b. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) <b>Baltimore City</b></p>		<p>12. CITIZEN OF WHAT COUNTRY?</p>	
<p>13. FATHER'S NAME <b>John Gray</b></p>				<p>14. MOTHER'S MAIDEN NAME <b>Anna R. Forrester</b></p>			
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)</p>				<p>16. SOCIAL SECURITY NO.</p>			
<p>17. INFORMANT <b>Thos Forrester</b></p>				<p>Address</p>			
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p>							
<p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia and Malnutrition.</b> 1773X DUE TO</p>							
<p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)</p>							
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>							
<p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>				<p>INTERVAL BETWEEN ONSET AND DEATH</p>			
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p>				<p>20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18)</p>			
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19</p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>							
<p>ACTUAL SIGNATURE <b>Charles S. Gray</b> M.D.</p>				<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/></p>			
<p>EXAMINER'S NAME (Type)</p>				<p>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/></p>			
<p>DEPUTY MEDICAL EXAMINER <input type="checkbox"/></p>				<p>DATE SIGNED <b>2/7/61</b></p>			
<p>Address (Street, city, town, or county)</p>							
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b></p>		<p>22b. DATE THEREOF <b>2/4/61</b></p>		<p>22c. NAME OF CEMETERY OR CREMATORY <b>Charles</b></p>		<p>22d. LOCATION (City, town, or country) (State) <b>West River Md.</b></p>	
<p>23. FUNERAL DIRECTOR <b>Thos Forrester</b></p>				<p>ADDRESS</p>			
<p>24a. REC'D BY REGISTRAR <b>DATE FEB 17 '61</b></p>		<p>24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b></p>					

MEDICAL CERTIFICATION

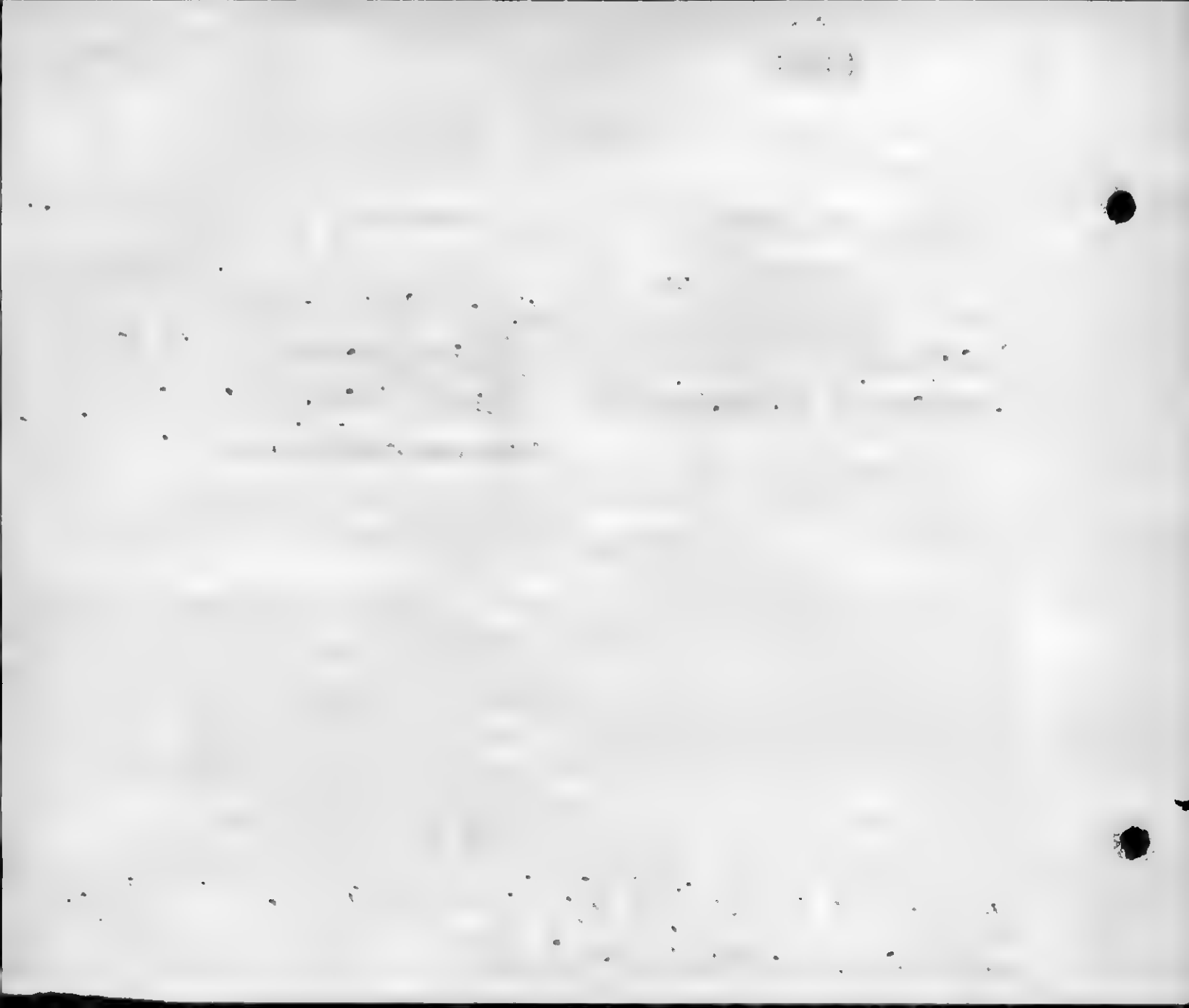


1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
1465  
CERTIFICATE OF DEATH

01445

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY (If not in hospital, give street address) <u>Arnold</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u> d. STREET ADDRESS <u>Joyce Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Anne Arundel General</u> First <u>Charles</u> Middle <u>Griffin</u> Last <u>Griffin</u>		4. DATE OF DEATH <u>Feb. 3 19 61</u> Month Day Year	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>4-6-1889</u> 9. AGE (In years last birthday) <u>71</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin Griffin</u> 14. MOTHER'S MAIDEN NAME <u>Mary Hammond</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) 16. SOCIAL SECURITY NO. <u>Lawrence Griffin Arnold Md.</u> 17. INFORMANT <u>Griffin</u> Address <u>Arnold Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-Vascular Disease.</u> DUE TO (b) <u>(Myocardial Failure)</u> DUE TO (c) <u>(Myocardial Failure)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>69</u> <u>Months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>28 31 1960</u> to <u>4 3 1961</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>U.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Arthur S. Thayer</u>		22b. DATE SIGNED <u>Feb 9 1961</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL; CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
<u>Burial</u>		<u>2-8-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
<u>Mt. Calvary</u>		<u>Arnold Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reesett</u>		25. REC'D BY REGISTRAR <u>Arthur S. Thayer</u>	
25a. ADDRESS		25b. REGISTRAR'S SIGNATURE	
<u>Arnold Md.</u>		<u>Arthur S. Thayer</u>	
DATE <u>FEB 9 '61</u>			



TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

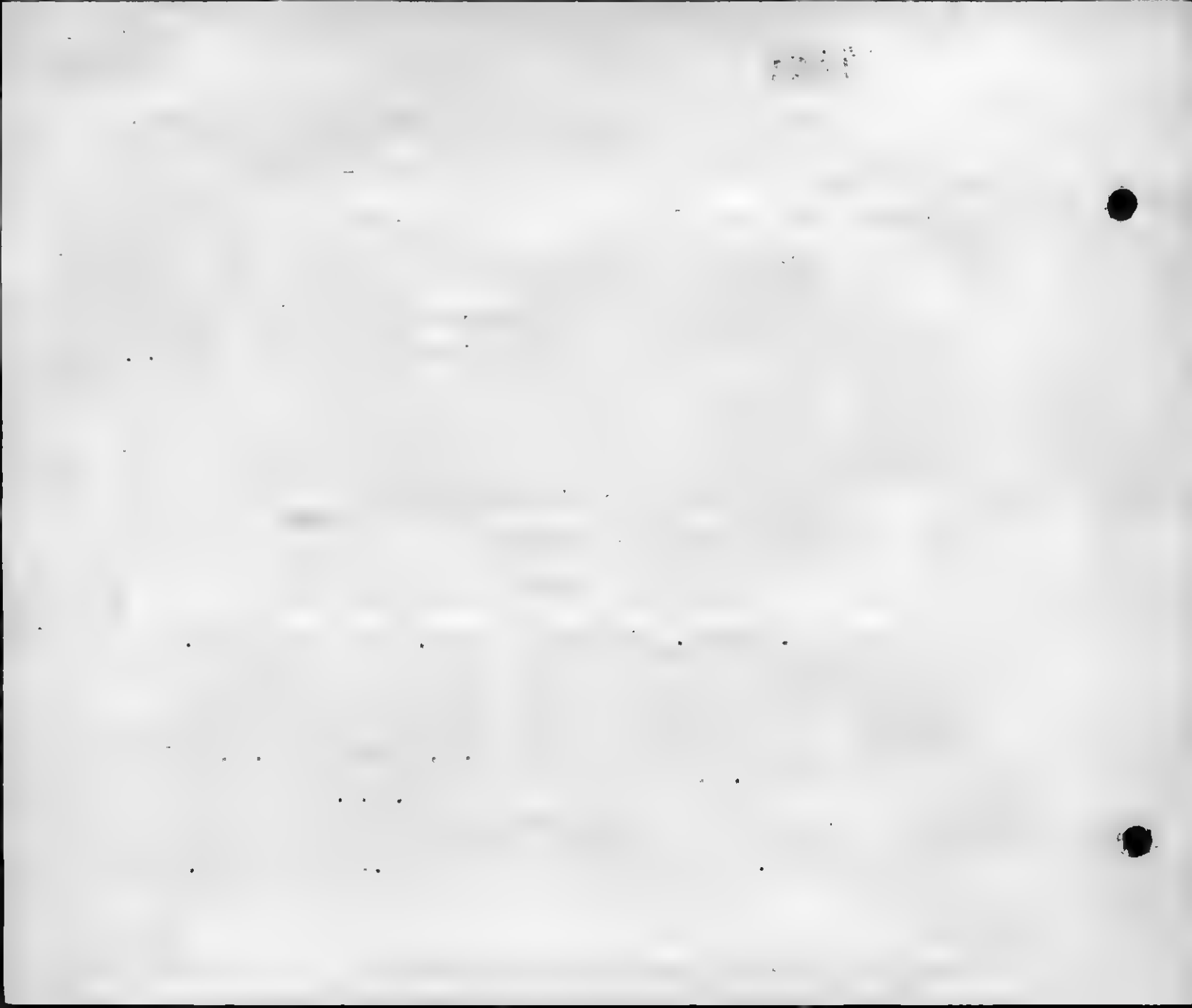
1466

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01446

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>8 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Severn</u>			
3. NAME OF DECEASED (Type or print) <u>Annie</u> First Middle Last				4. DATE OF DEATH <u>February 9 19 61</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 28, 1899</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Hudson Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Ida Nelson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				17. INFORMANT <u>Madeline Brown</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anterior Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cardiac decompensation</u> (a), stating the underlying cause last. DUE TO (c) <u>Hypertensive cardiovascular renal disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Diabetes mellitus. Uremia. Bilateral cataracts. Chronic leg ulcers.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>Physician</u> attended the deceased from <u>Feb. 1, 1961</u> to <u>Feb. 8, 1961</u> , that (I) <u>Yes</u> last saw the deceased alive on <u>Feb. 8, 1961</u> , and that death occurred at <u>1:25 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Lionel McH. Mapp</u> M.D.				22b. DATE SIGNED <u>Feb. 1, 1961</u>		22c. PHYSICIAN'S NAME (Type) <u>Lionel McH. Mapp</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>2/11/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Private Burial Lot East End</u>		23d. LOCATION (City, town or county) (State) <u>U.A.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William S. Phillips</u> ADDRESS <u>1808 N. Mermaid St.</u>				25a. REC'D BY REGISTRAR <u>Feb 14 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

I



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

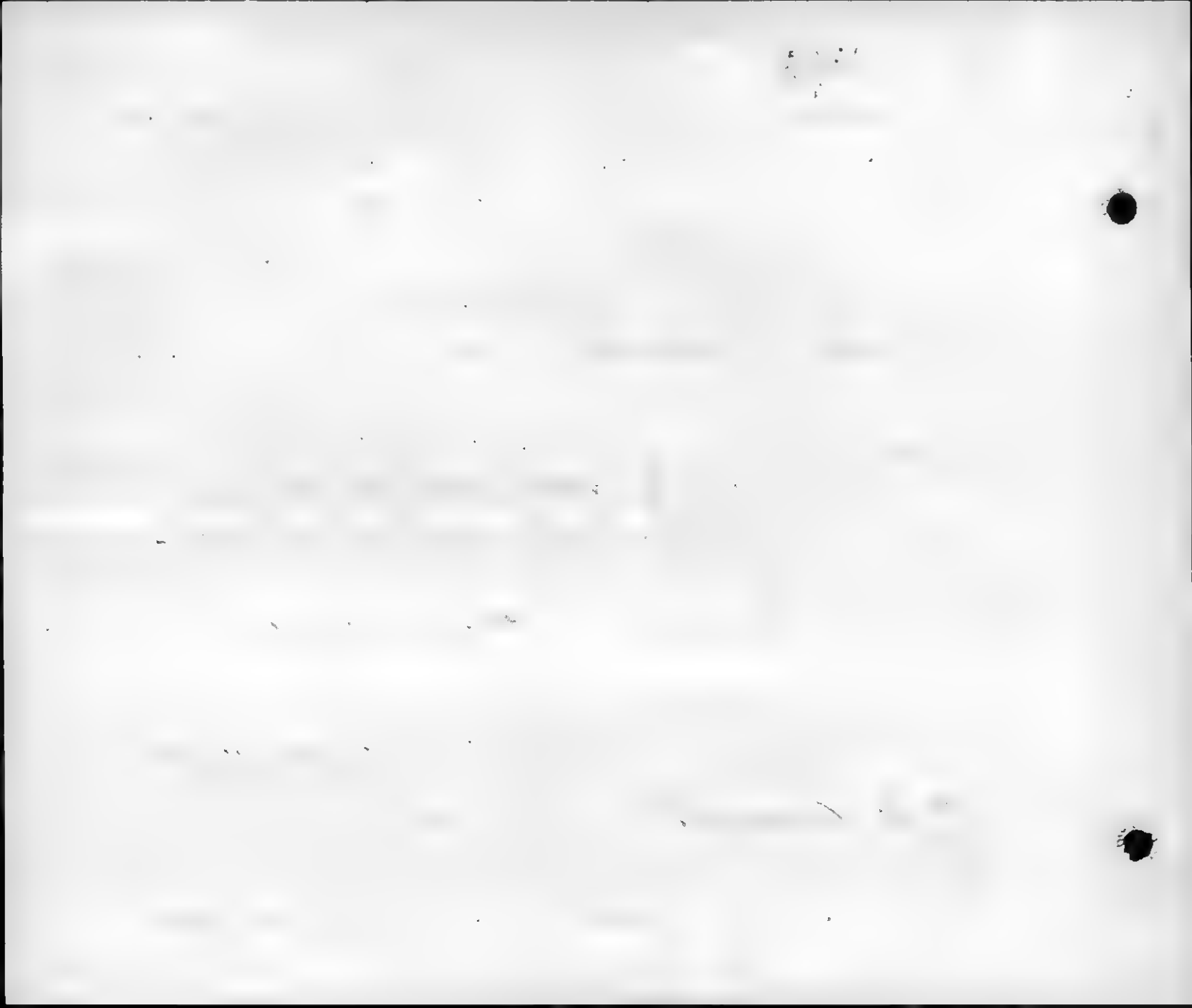
1467

Items 4, 13, 14 Film 201-2-27-61 et

01447

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Magothy Beach</b> c. LENGTH OF STAY IN 1b <b>6 yrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Riverside Drive</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Magothy Beach</b> d. STREET ADDRESS <b>Riverside Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Frederick William</b> Middle <b>Heikel</b> Last 4. DATE OF DEATH Month <b>Feb.</b> Day <b>12</b> Year <b>1961</b>		5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>May 25, 1885</b> 9. AGE (In years last birthday) <b>75</b> yrs IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Brick Contractor</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b> 11. BIRTHPLACE (State or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		13. FATHER'S NAME <b>John Heikel</b> 14. MOTHER'S MAIDEN NAME <b>Johana Scheir</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> 16. SOCIAL SECURITY NO. <b>1</b> 17. INFORMANT <b>Mrs. Catherine Heikel</b> Address <b>Same</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute pulmonary embolism</b> DUE TO <b>Antenarobotic cardiovascular disease</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>2 1/2 hours</b> DUE TO (c) <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I(a): <b>Carcinoma of the prostate gland 11 years</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (the hospital) attended the deceased from <b>August 10 1909</b> to <b>February 12 1961</b> , that (I) (we) last saw the deceased alive on <b>Feb. 7 1961</b> , and that death occurred at <b>6 A. M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>R. M. McLaughlin</b> 22c. PHYSICIAN'S NAME (Type) <b>R. M. McLaughlin</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>3708 Mountain Rd. Pasadena, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>Feb. 15, 1961</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Pr.</b> 23d. LOCATION (City, town, or county) (State) <b>Glen Burnie, Maryland</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>George J. Gonce</b> ADDRESS <b>4001 Ritchie Hwy. (25)</b> DATE <b>FEB 16 '61</b> 25a. REC'D BY REGISTRAR <b>Charles L. F...</b> 25b. REGISTRAR'S SIGNATURE	

George J. Gonce





1468

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

01448

1. PLACE OF DEATH a. COUNTY Anne Arundel				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie,				c. LENGTH OF STAY IN 1b 5 yrs.				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland				b. COUNTY Anne Arundel			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 101 Third Ave., S.E.								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last AMELIA J. HELMER				4. DATE OF DEATH Month Day Year February 26, 1961															
5 SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 17th July '74		9. AGE (In years lost birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (State or foreign country) Germany				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Lockmann								14. MOTHER'S MAIDEN NAME (Unknown) Roas											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. unknown				17. INFORMANT Mrs. Stensberry, Same As #2				Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.1 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 10-12 3/4 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												INTERVAL BETWEEN ONSET AND DEATH 2-3 1/2							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from Jan 16, 1961, to Feb 26, 1961, that (I) (we) last saw the deceased alive on Feb 26, 1961, and that death occurred at M, from the causes and on the date stated above.																			
22a. SIGNATURE Glen S. Ballew				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22b. DATE SIGNED 1/2/61											
22c. PHYSICIAN'S NAME (Type) Glen S. Ballew				22d. ADDRESS Glen Burnie, Md.															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 1st March 1961		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				23d. LOCATION (City, town, or county) (State) Brooklyn, RFD, Maryland									
24. FUNERAL DIRECTOR'S SIGNATURE R. P. Bright				ADDRESS Glen Burnie, Md.				25a. REC'D BY REGISTRAR DATE MAR 3 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus									



# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
<div style="display: flex; justify-content: space-between;"> <div> <p>1469</p> <p>Items 7, 22b, 22c, 22d, 22e, 22f, 22g, 22h, 22i, 22j, 22k, 22l, 22m, 22n, 22o, 22p, 22q, 22r, 22s, 22t, 22u, 22v, 22w, 22x, 22y, 22z, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000</p> </div> </div>									
<p>1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b></p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Curtis Bay</b></p> <p>c. LENGTH OF STAY IN b. <b>U.S. Coast Guard Dispensary</b></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1049 Blaine Street</b></p>									
<p>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Indiana</b> b. COUNTY <b>Indianapolis</b></p> <p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Indianapolis</b></p> <p>d. STREET ADDRESS <b>1049 Blaine Street</b></p>									
<p>3. NAME OF DECEASED (Type or print) <b>HAROLD ALAN HOWARD</b></p> <p>4. DATE OF DEATH <b>February 28 1961</b></p> <p>5. SEX <b>Male</b></p> <p>6. COLOR OR RACE <b>White</b></p> <p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p> <p>8. DATE OF BIRTH <b>June 1, 1922</b></p> <p>9. AGE (In years last birthday) <b>38</b> yrs. <b>38</b> yrs.</p> <p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy</b></p> <p>10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b></p> <p>11. BIRTHPLACE (State or foreign country) <b>Indiana</b></p> <p>12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b></p>									
<p>13. FATHER'S NAME <b>Jack L. Hobbs</b></p> <p>14. MOTHER'S MAIDEN NAME <b>Frances Hobbs (Maiden)</b></p> <p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes June 7, 1942</b></p> <p>16. SOCIAL SECURITY NO. <b>316-16-0497</b></p> <p>17. INFORMANT <b>U.S. Customs, Norfolk, Va</b></p>									
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>420</b></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b></p>									
<p>19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/></p> <p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p> <p>20c. TIME OF INJURY Month, Day, Year <b>19</b></p> <p>20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/></p> <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p> <p>20f. (City or town) (County) (State)</p>									
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p> <p>CHIEF MEDICAL EXAMINER <input type="checkbox"/></p> <p>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/></p> <p>DEPUTY MEDICAL EXAMINER <input type="checkbox"/></p> <p>DATE SIGNED <b>3/1/61</b></p>									
<p>ACTUAL SIGNATURE <b>W. Bradley King, Jr., M.D.</b></p> <p>EXAMINER'S NAME (Type) <b>W. Bradley King, Jr., M.D.</b></p> <p>22a. BURIAL OR CREMATION, REMOVAL (Specify) <b>Removal</b></p> <p>22b. DATE THEREOF <b>3-1-61</b></p> <p>22c. NAME OF CEMETERY OR CREMATORY <b>Deer Funeral Home</b></p> <p>22d. LOCATION (City, town, or country) (State) <b>Washington, D.C.</b></p> <p>23. FUNERAL DIRECTOR <b>Deer Funeral Home, Inc.</b></p> <p>24a. REC'D BY REGISTRAR <b>Mar 3 '61</b></p> <p>24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b></p>									



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

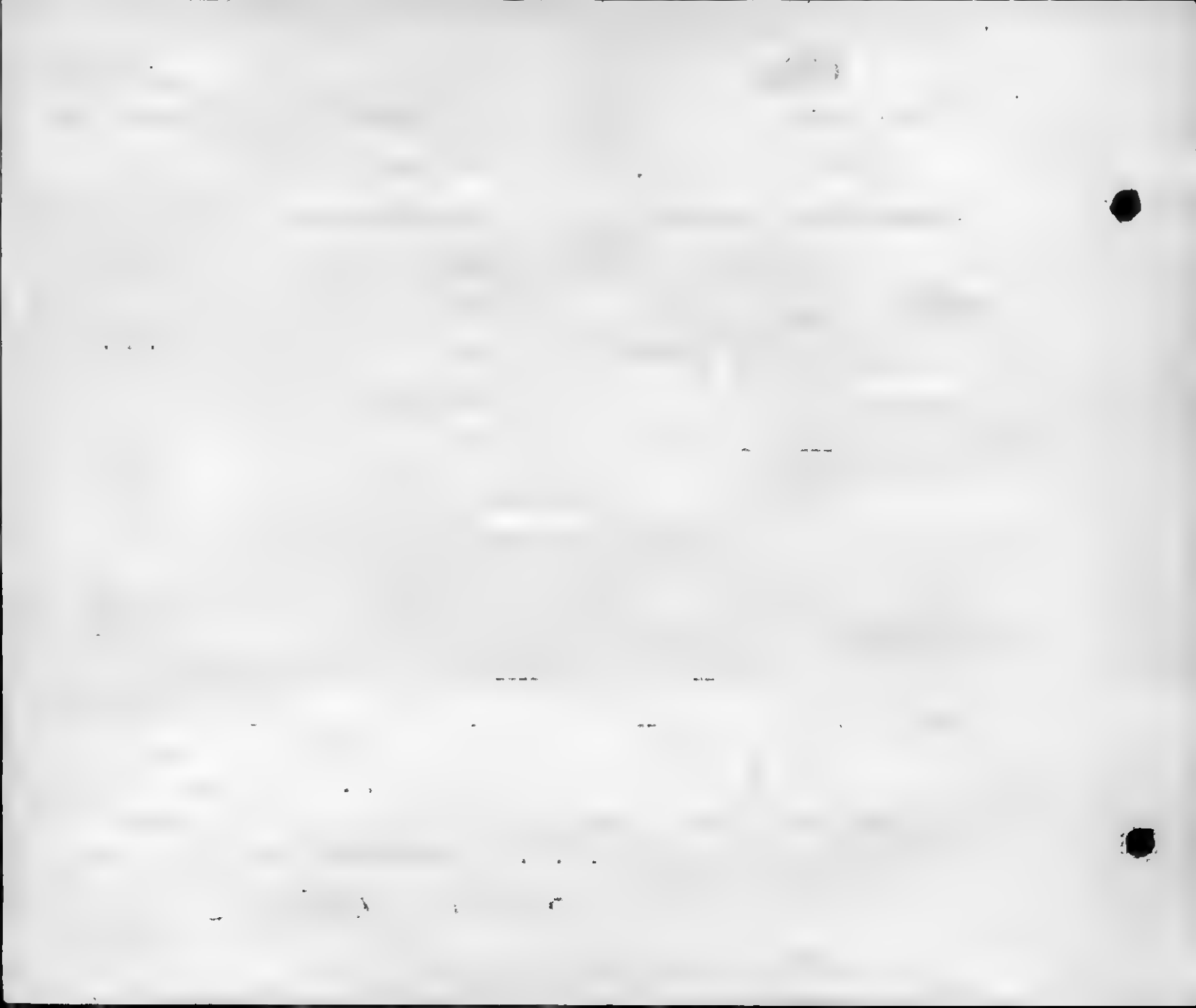
## CERTIFICATE OF DEATH

1470

01450

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>8 years 9 mos. 8 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Crownsville State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1419 Madison Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Ellen</b> Last <b>Johns</b>		4. DATE OF DEATH Month <b>2</b> Day <b>23</b> Year <b>19 61</b>	
5. SEX <b>Female</b> 6. COLOR OR RACE <b>Negro</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/8/91</b> 9. AGE (In years last birthday) <b>70</b> yrs. IF UNDER 1 YEAR: Months <b>70</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Blair</b>		14. MOTHER'S MAIDEN NAME <b>Annie Brown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give year or dates of service) <b>-----</b>		16. SOCIAL SECURITY NO. <b>Unknown</b> 17. INFORMANT <b>Hospital Records</b> Address <b>-----</b>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pericardial Tamponade</b> DUE TO (b) <b>Ruptured Aortic Aneurysm</b> DUE TO (c) <b>Syphilis</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chromophobe Adenoma of Pituitary</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <b>-----</b> 20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18) <b>-----</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>4/7/1951</b> to <b>2/23/1961</b> that (I) (we) last saw the deceased alive on <b>2/23/1961</b> and that death occurred at <b>3:48 A.M.</b> from the causes and on the date stated above.		22a. SIGNATURE <b>Hildegard Heard Reissman M.D.</b> 22b. DATE SIGNED <b>2/23/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissman, M. D.</b>		22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>2/28/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Airy Cemetery</b> 23d. LOCATION (City, town or county) <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>C.O. Wilson</b> 25a. REC'D BY REGISTRAR <b>FEB 27 1961</b> 25b. REGISTRAR'S SIGNATURE <b>Robert L. Thomas</b>		25c. ADDRESS <b>1000 Bruce Hwy</b>	

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



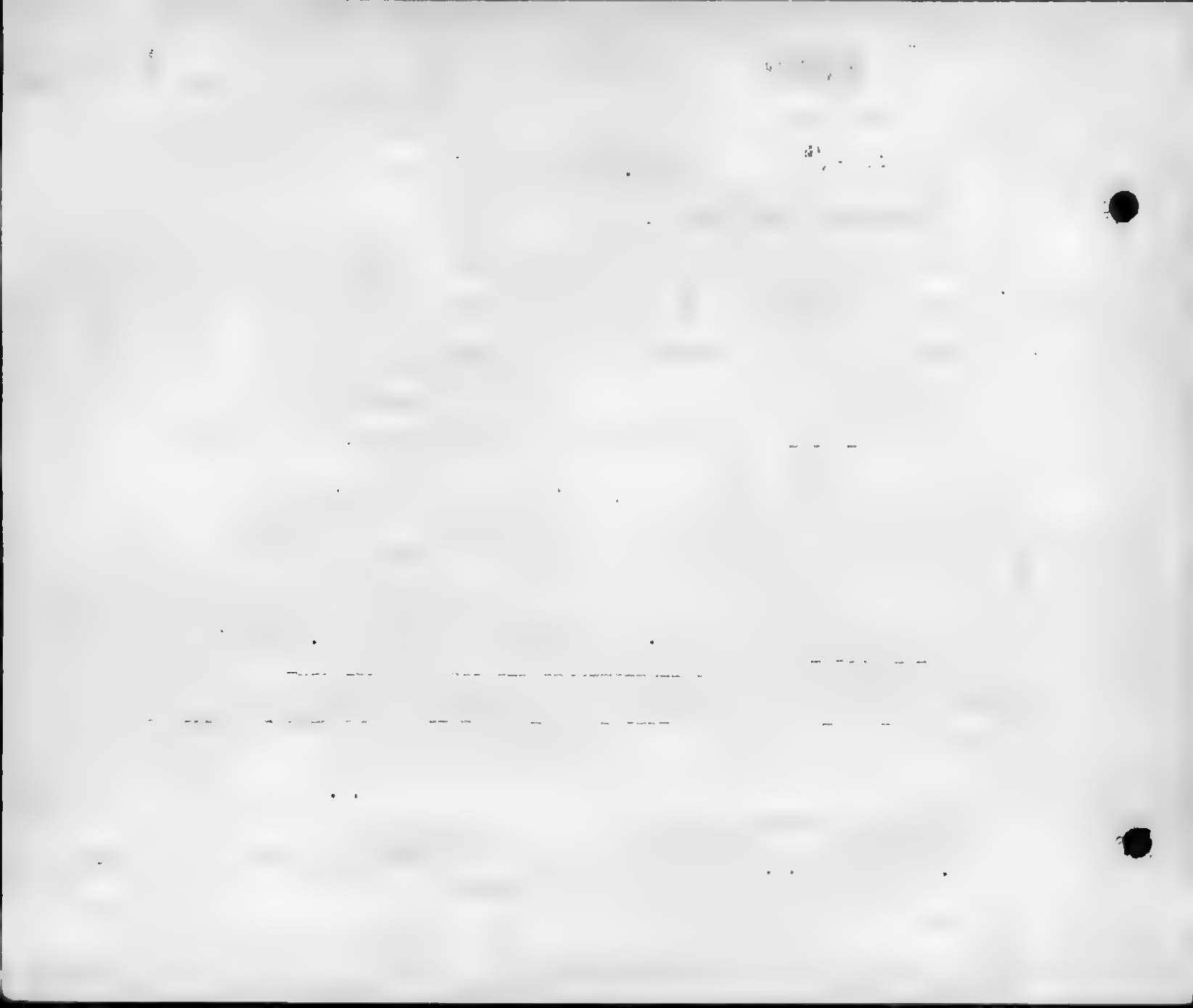
1  
See 7M3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
1471											
01451											
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>				c. LENGTH OF STAY IN 1b <b>20 years</b> <b>8 mos. 25 days</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>Unknown</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Jennie</b> Middle Last <b>Jones</b>				4. DATE OF DEATH Month <b>2</b> Day <b>19</b> Year <b>1961</b>							
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1879</b>		9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>				11. BIRTHPLACE (County & State, or foreign country) <b>North Carolina</b>			
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <b>Dennis Barnett</b>				14. MOTHER'S MAIDEN NAME <b>Martha Overton</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>				17. INFORMANT <b>Hospital Records</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b>											
DUE TO (b) _____											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>Chronic Brain Syndrome asso. with Senile Brain Disease w. Psychosis</b>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <b>5/24/1961</b> to <b>2/19/1961</b> , that (I) (we) last saw the deceased alive on <b>2/19/1961</b> , and that death occurred at <b>12:15</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>L. Benedict, M.D.</b>											
22b. DATE SIGNED <b>2/19/61</b>											
22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M.D.</b>											
22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>											
23b. DATE THEREOF <b>28 Feb. 61</b>											
23c. NAME OF CEMETERY OR CREMATION ADDRESS <b>Univ. of Md. Annapolis, Md.</b>											
23d. LOCATION (City, town or county) (State) <b>Baltimore Md.</b>											
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Reese II</b>											
25a. REC'D BY REGISTRAR <b>MAR 6 '61</b>											
25b. REGISTRAR'S SIGNATURE <b>Charles L. Kraus</b>											





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 48 hours after death.

VR A15 (4)  
15M 9/59

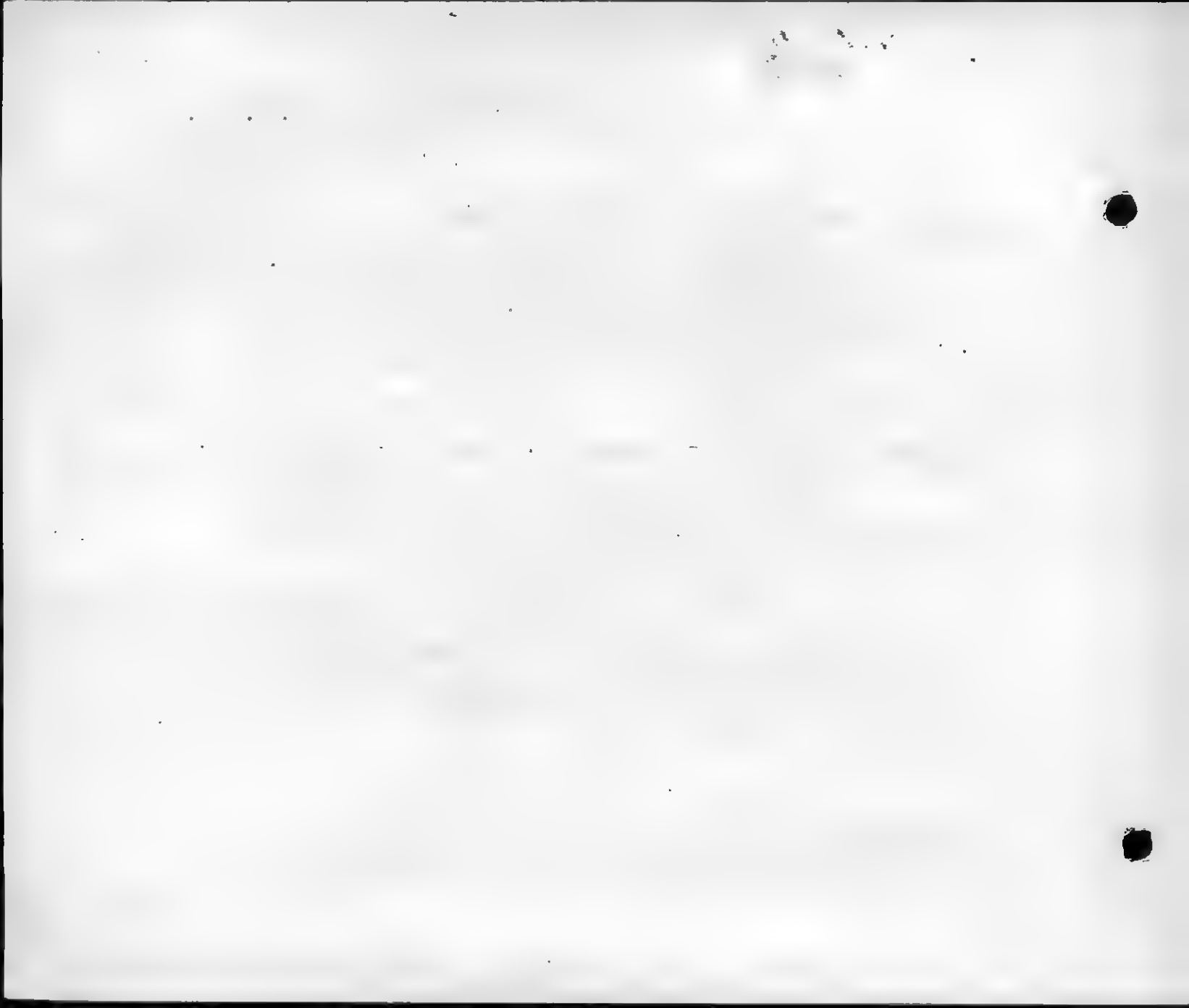
1472

1472

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01452

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gibson Island</b>		c. LENGTH OF STAY IN 1b <b>X</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>A. A. Co.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Gibson Island</b>		d. STREET ADDRESS <b>1 Skippers Row</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <b>Arthur Rhodes Knight</b>		First <b>Arthur</b>		Middle <b>Rhodes</b>		Last <b>Knight</b>		4. DATE OF DEATH <b>Feb. 4, 1961</b>		Month <b>Feb.</b>		Day <b>4</b>		Year <b>19</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Apr. 10, 1886</b>		9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY?									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Consulting Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Rhode Island</b>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Arthur Knight</b>		14. MOTHER'S MAIDEN NAME <b>Mary Howland</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-01-1554</b>		17. INFORMANT <b>Mrs. Seaton Reed-Butler, Indiana</b>		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 DUE TO</b> Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>year +</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Gibson Is</b>		20f. (City or town) <b>Anne Arundel Md</b>		(County) <b>Anne Arundel</b>		(State) <b>Md</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>2/4</b> <b>1961</b> to <b>2/4</b> <b>1961</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>1:45 PM</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>Robert E. Cooke</b>		M.D. <b>Robert E. Cooke M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> <b>2/4/61</b>		22b. DATE SIGNED <b>2/4/61</b>		22c. PHYSICIAN'S NAME (Type) <b>Robert E. Cooke M.D.</b>		22d. ADDRESS <b>Gibson Is, Md</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>2-9-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>--</b>		23d. LOCATION (City, town, or county) <b>Springfield, Ohio</b>		(State) <b>Ohio</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm J. Dickner &amp; Sons</b>		ADDRESS <b>Balto 17, Md</b>		25a. REC'D BY REGISTRAR <b>21</b>		25b. REGISTRAR'S SIGNATURE		25c. DATE		25d. TIME		25e. OFFICE		25f. COUNTY		25g. STATE		25h. CITY		25i. ZIP			



CERTIFICATE OF DEATH

Reg. Dist. No. 01453

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN lb <u>1 mo.</u>		d. STREET ADDRESS <u>808 N. Mountford Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>809 2nd Ave. Marley</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>KOMIN</u> Last <u>KOMIN</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>4</u> Year <u>1961</u>	
5 SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 11, 1885</u>
9 AGE (In years last birthday) <u>75</u> yrs		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Receiving Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Universal Car Loading Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Albert Komin</u>		14. MOTHER'S MAIDEN NAME <u>Caroline</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-14-1670</u>	
17. INFORMANT <u>Albert J. Komin</u>		Address <u>1801 August Ave. Balto.-22-</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cordiac Failure</u> DUE TO <u>Coronary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilateral Angiostenosis from Atherosclerotic Lesions</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II or item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9 Jan. 1961</u> , to <u>29 Jan. 1961</u> , that I last saw the deceased alive on <u>29 Jan. 1961</u> , and that death occurred at <u>  </u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Melvin H. Crocker</u> M.D. <u>1961</u>		ADDRESS (Street, city or town, state) <u>1204 St. Paul Street</u> DATE SIGNED <u>2-7-61</u>	
PHYSICIAN'S NAME (Type) <u>Melvin H. Crocker, M. D.</u>		<u>Baltimore 2, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2-8-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Philip E. Cwach</u>		ADDRESS <u>1211 Chesaco Ave. Balto.-6</u>	
24a. REC'D BY REGISTRAR <u>  </u> DATE FEB 10 '61		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 01454

1474

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Severn	
c. LENGTH OF STAY IN 1b 38 yrs		d. STREET ADDRESS 1 Route 1, Box 256	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 1, Box 256		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ZOFIA (SOPHIE) KOZLOWSKA		4. DATE OF DEATH February 4, 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 4, 1879
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Peter Helinski		14. MOTHER'S MAIDEN NAME Victoria Pleban	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Stella Tipton, Rte. 1, Box 256, Severn, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Anterior sclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1960, to Feb 4 1961, that I last saw the deceased alive on Feb 4 1961, and that death occurred at 2:05 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward G. Skerritt M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 62 mb 1/15 Md 2-5-61	
PHYSICIAN'S NAME (Type) Edward G. Skerritt		Gambrills, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/8/61	22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus	22d. LOCATION (City, town or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M.F. SADOWSKI & SONS, 1808 EASTERN AVE		24a. REC'D BY REGISTRAR DATE FEB 7 '61	
		24b. REGISTRAR'S SIGNATURE	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1475 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **01455**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>AA</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b _____ d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>AA General Hosp't.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>AA</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Davidsonville</u> d. STREET ADDRESS <u>W. F. T. Annapolis</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Verbal</u> Middle <u>Laster</u> Last <u>Laster</u>				<b>4. DATE OF DEATH</b> Month <u>2</u> Day <u>9</u> Year <u>1961</u>													
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Feb 2-1919</u>		<b>9. AGE</b> (In years last birthday) <u>42</u> yrs. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS															
Months	Days	Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Wheat Corn Etc</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Tenn</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A</u>									
<b>13. FATHER'S NAME</b> <u>James W. Laster</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Kate Sengbush</u>													
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Mildred Laster</u> Address <u>(2)</u>													
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>																	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)											
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> , <b>Inspection</b> <input checked="" type="checkbox"/> , <b>Inquiry</b> <input type="checkbox"/> , and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																	
<b>ACTUAL SIGNATURE</b> <u>E. L. Linhardt</u>				<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>													
<b>EXAMINER'S NAME (Type)</b> <u>E. L. Linhardt</u>				<b>DATE SIGNED</b> <u>2-9-61</u>													
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>2-12-1961</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Davidsonville Methodist</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>Davidsonville Md</u>											
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John M. Taylor Sr</u> ADDRESS <u>Annapolis Md</u>				<b>24a. REC'D BY REGISTRAR</b> <u>FEB 14 '61</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hume</u>											

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





1476

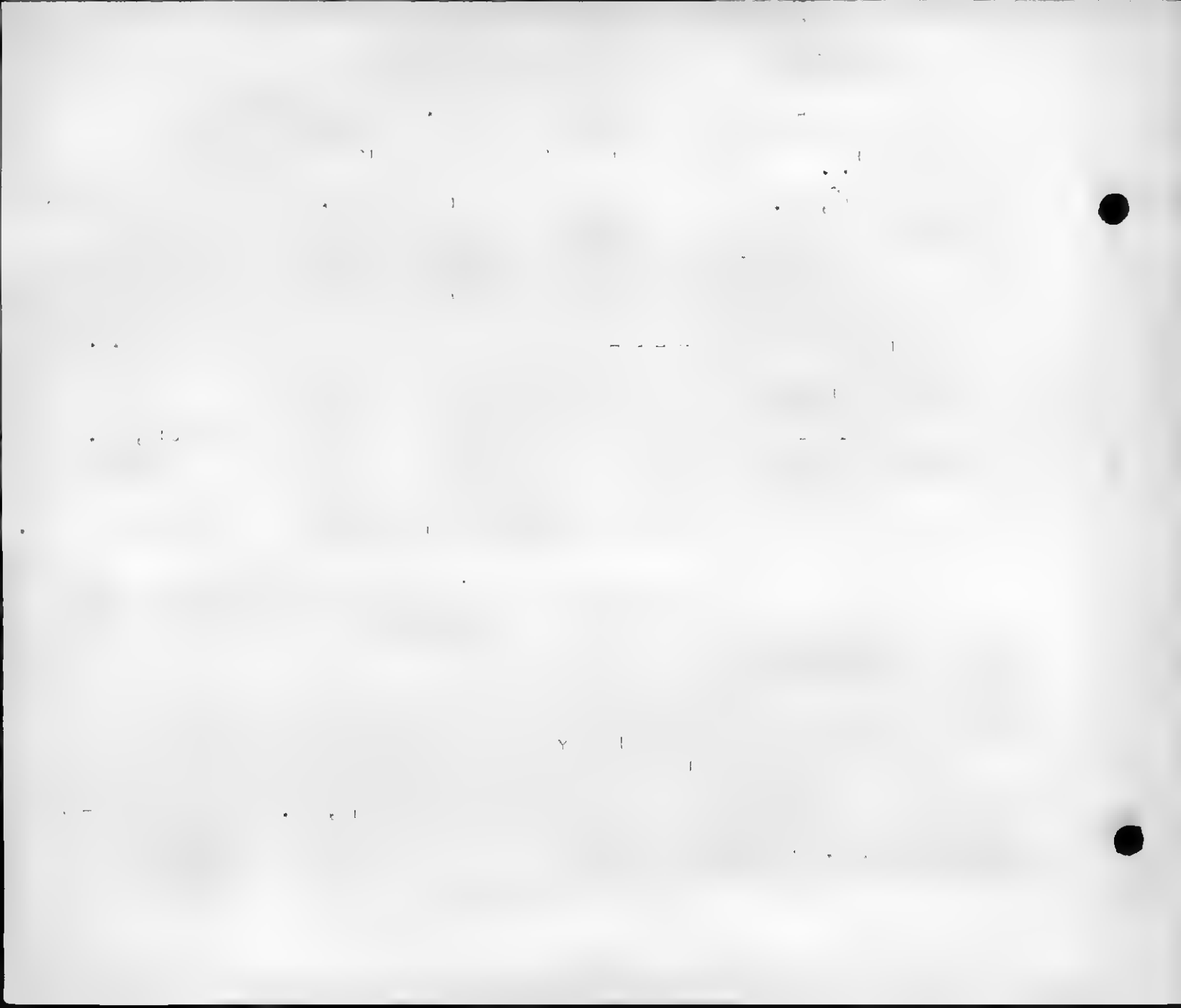
## CERTIFICATE OF DEATH

Reg. Dist. No. 01456

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>ANNE ARUNDEL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>				c. LENGTH OF STAY IN 1b <b>11 YEARS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USNH ANNAPOLIS, MD.</b>				d. STREET ADDRESS <b>712 GIDDINGS AVE.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>RUSSELL</b> Middle <b>DURR</b> Last <b>LATIMER</b>				4. DATE OF DEATH Month <b>FEB</b> Day <b>11</b> Year <b>1961</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>CAU</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4 DEC 1889</b>	
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>11</b> Hours <b>11</b> Min <b>11</b>		IF UNDER 24 HRS Months <b>7</b> Days <b>11</b> Hours <b>11</b> Min <b>11</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-- -- --</b>		11. BIRTHPLACE (State or foreign country) <b>FLORIDA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>RALPH MUNLIN DURR</b>				14. MOTHER'S MAIDEN NAME <b>ACHSAR MARTHA SMITH</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO <b>-- -- --</b>		17. INFORMANT <b>USNH HOSPITAL</b>	
Address <b>ANNAPOLIS, MD.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]				INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b>			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1-4X DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CARCINOMATOSIS (RECTUM)</b> (c) <b>OVER 1 1/2 YRS.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>1 JULY</b> , 19 <b>60</b> , to <b>11 FEB</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>11 FEB</b> , 19 <b>61</b> , and that death occurred at <b>9:33A</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>USNH ANNAPOLIS, MD.</b> DATE SIGNED <b>2-11-61</b>							
ACTUAL SIGNATURE <b>S. B. HILTABIDLE</b>				M.D. <b>USNH ANNAPOLIS, MD.</b>			
PHYSICIAN'S NAME (Type) <b>S. B. HILTABIDLE LT MC USN</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-13-1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor Sins</b>				ADDRESS <b>Annapolis Md</b>		24a. REC'D BY REGISTRAR DATE <b>14 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles E. Hume</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or is designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 1477 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01457

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Severn</b> c. LENGTH OF STAY IN b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Box 69 Route 2</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Same</b> b. COUNTY <b>Same</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Same</b> d. STREET ADDRESS <b>Same</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Sethille Leach</b>		4. DATE OF DEATH Month Day Year <b>Feb. 3 19 61</b>		5. SEX <b>F</b>	
6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/15/03</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (in years last birthday) <b>57</b>	
11. BIRTHPLACE (State or foreign country) <b>Snowhill, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>?</b>	
14. MOTHER'S MAIDEN NAME <b>?</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Daughter</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Charred to death</b> 7/6.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Few seconds</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fire broke out in her home and she could be rescued</b>		20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>2:AM</b> p.m. <b>2/3/61</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Severn</b>		(County) <b>A.A.</b>	
(State) <b>Md.</b>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/8/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>	
22d. LOCATION (City, town, or country) <b>Belair, Maryland</b>		22e. (State) <b>Md.</b>		22f. DATE SIGNED <b>2/3/61</b>	
23. FUNERAL DIRECTOR <b>Hopping &amp; Kirkley, Glen Burnie, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 7 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

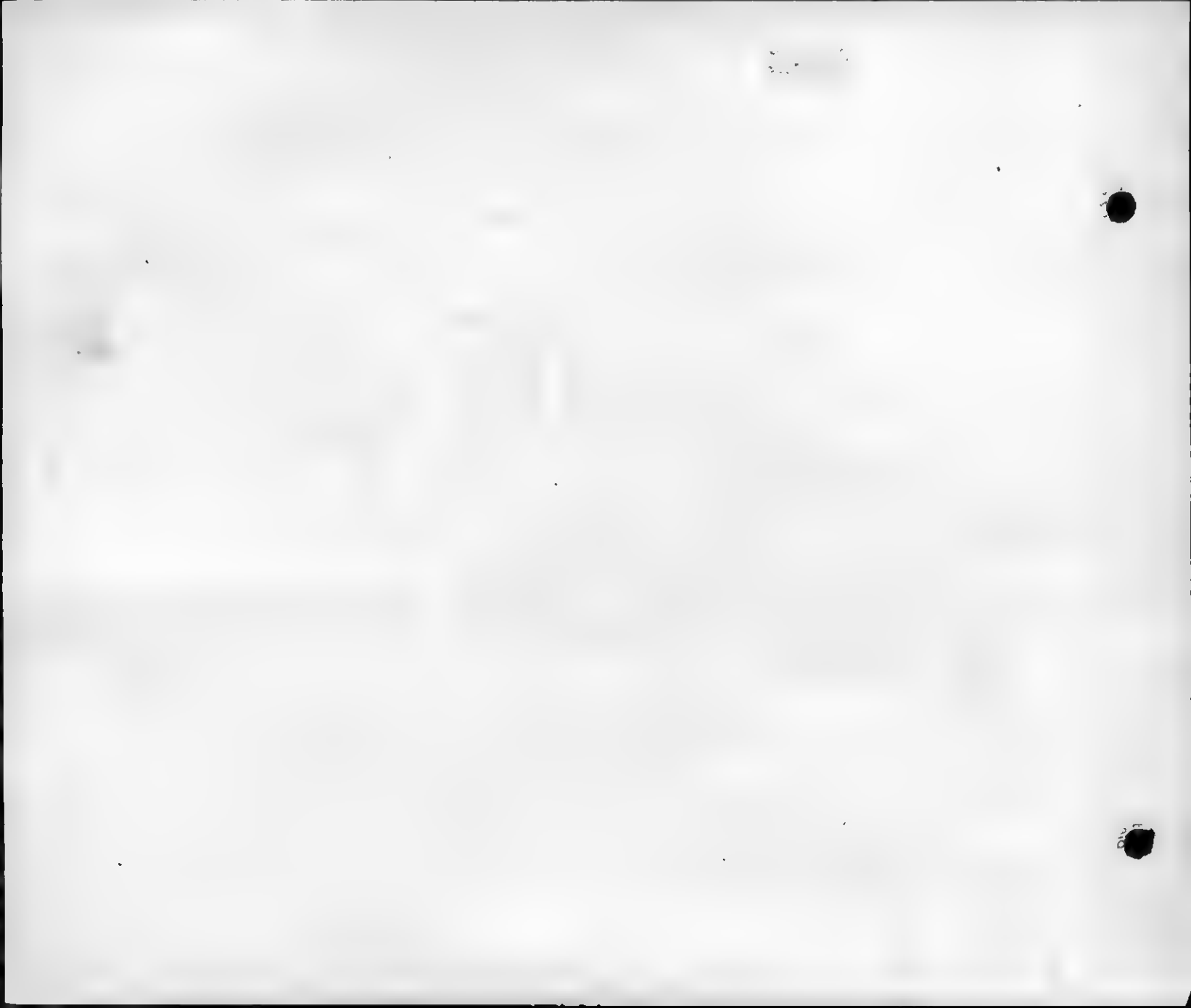
MEDICAL CERTIFICATION



1  
52  
11  
X  
I  
O  
1  
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1478  
1458  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pasadena</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL PASADENA</u> X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 498 Pasadena</u>		d. STREET ADDRESS <u>MAGOTHY BEACH RD Box 498</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Thomas Lee</u>		4. DATE OF DEATH Month Day Year <u>Feb. 6 1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 2, 1900</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardener</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Rev. Milton Lee</u>		14. MOTHER'S MAIDEN NAME <u>Ola Mae -</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>215-12-4663</u>	
17. INFORMANT <u>Lauraine Lee (wife)</u> same Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> DUE TO (b) <u>Arteriosclerotic Cardio Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>and Neurovascular syphilis</u> (c) <u>Neurovascular syphilis</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 6, 1961</u> to <u>19</u> that (I) (we) last saw the deceased alive on <u>19</u> and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above	
22a. SIGNATURE <u>C. Earl Hill</u> M.D.		22b. ADDRESS <u>7819 Bridge Drive, Balto. 26</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. Earl Hill, M.D.</u>		22d. ADDRESS <u>7819 Bridge Drive, Balto. 26</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/10/1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion</u>		23d. LOCATION (City, town or county) (State) <u>Magothy Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Marshall P. Hays</u> ADDRESS <u>638 N. GILMORE ST BALTO 17 MD</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 9 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hays</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be received by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9-59

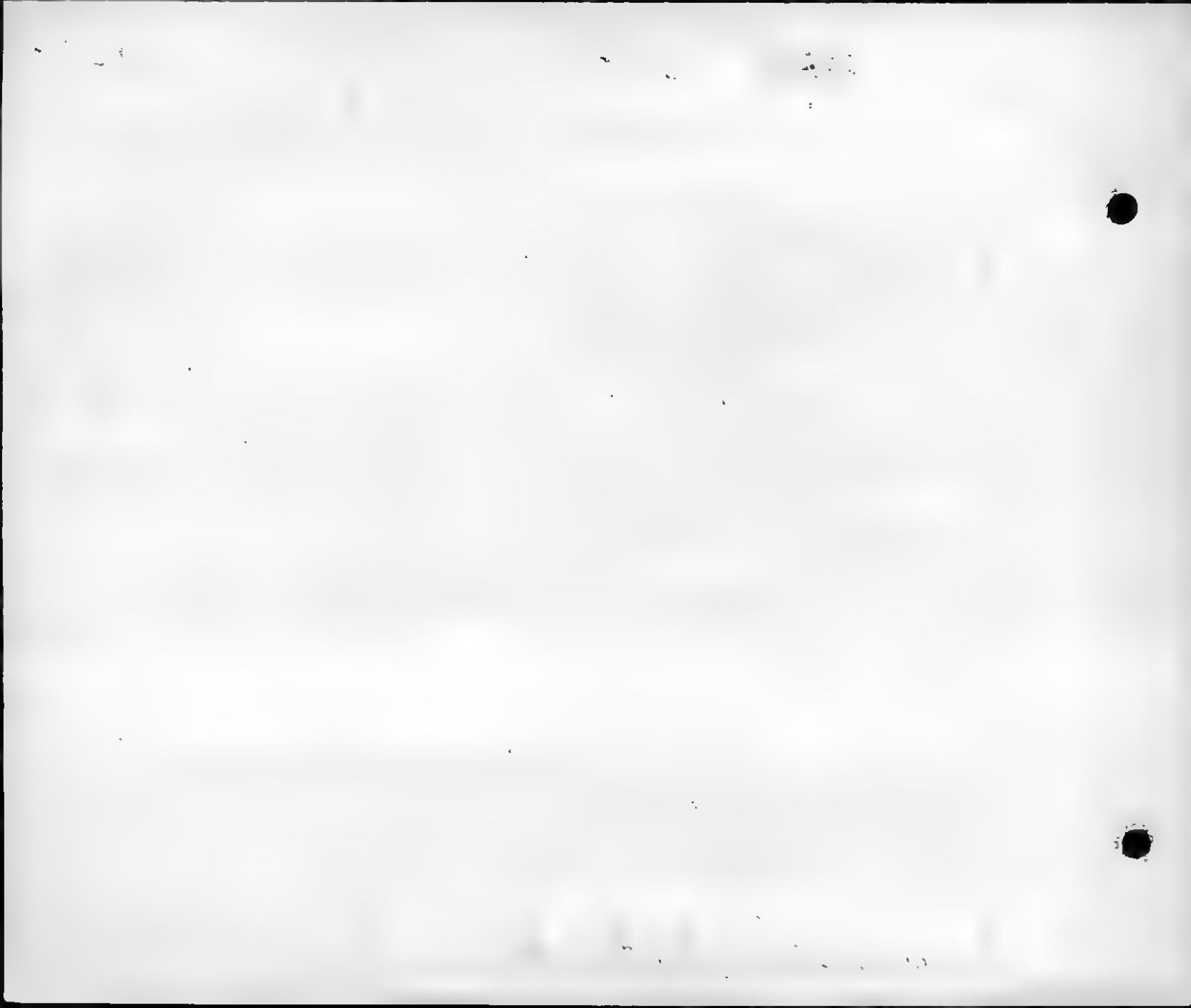
1479

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01459

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u> c. LENGTH OF STAY IN 1b <u>X</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stevenson Rd - Rt. 1 - Box 443 A</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X</u> d. STREET ADDRESS <u>Stevenson Rd - Rt. 1 - Box 443 A</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>A</u> Last <u>Liebno</u>			4. DATE OF DEATH Month <u>Feb</u> Day <u>22</u> Year <u>1961</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 31 - 1960</u>	9. AGE (In years lost birthday) yrs. <u>1</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>21</u> Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, md</u>			
13. FATHER'S NAME <u>Walter D. Liebno</u>		14. MOTHER'S MAIDEN NAME <u>Mary J. Heinz</u> SAME as <u>NO # 2</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u></u> (If yes, give war or dates of serv. ce) <u></u>		16. SOCIAL SECURITY NO <u>NONE</u>		17. INFORMANT <u>Mr. Walter D. Liebno</u> Address <u></u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe upper respiratory infection</u> <u>15X</u> DUE TO (b) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u></u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>			
		20f. (City or town) <u></u> (County) <u></u> (State) <u></u>					
21. I certify that (I) (this hospital) attended the deceased from <u>2/18</u> 19 <u>61</u> , to <u>2/22</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>2/22</u> 19 <u>61</u> , and that death occurred at <u>6A</u> M, from the causes and on the date stated above							
22a. SIGNATURE <u>H. W. Scheye</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED. <u>2/23/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>H. W. SCHEYE MD</u>		22d. ADDRESS <u>3230 MOUNTAIN RD</u>					
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb 24 - 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Haven Cemetery</u>			
				23d. LOCATION (City, town, or county) <u>Blenn Burnie</u> (State) <u>md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Singleton Funeral Home, Blenn Burnie, Md.</u>		25a. REC'D BY REGISTRAR <u></u> DATE <u>FEB 24 '61</u>		25b. REGISTRAR'S SIGNATURE <u>C. Short &amp; Kraw</u>			

VR A15 (4)  
15M 9-59





1480

## CERTIFICATE OF DEATH

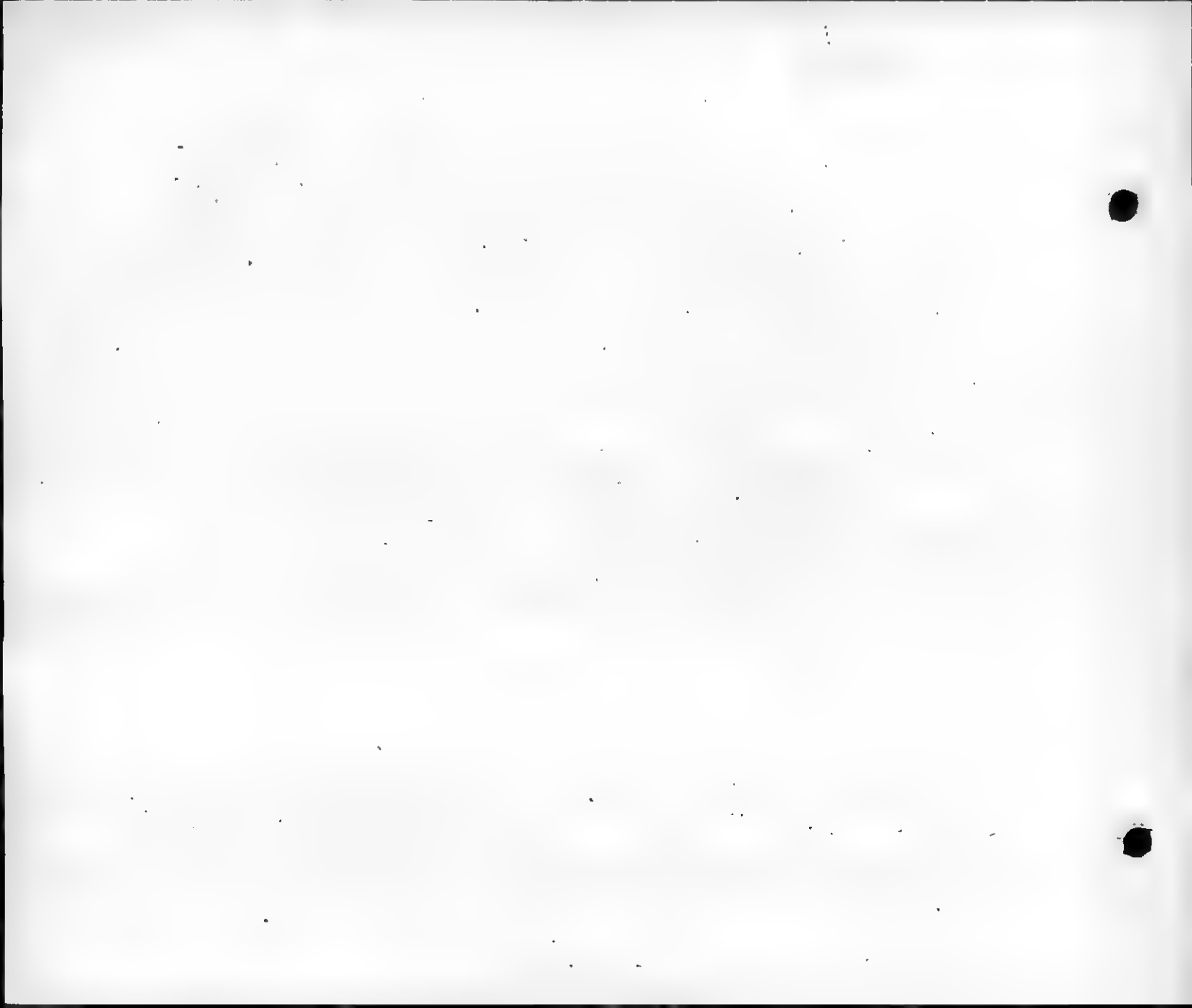
01460

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. A. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park MD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>KNOLLWOOD MANOR</u>		e. STREET ADDRESS <u>1000 County Rd</u>	
3. NAME OF DECEASED (Type or print) <u>STAND</u> First Middle Last <u>MADSEN</u>		4. DATE OF DEATH <u>2-26-61</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 15 1872</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Form</u>	
11. BIRTHPLACE (State or foreign country) <u>Denmark</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Christian Madsen</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Son Elmer Madsen</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>422.1</u> DUE TO, <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, <u>C.V. Disease</u> (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1959</u> 19 to <u>1961</u> 19, that I last saw the deceased alive on <u>2-18-61</u> 19, and that death occurred at <u>1P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Holms</u>		ADDRESS (Street, city or town, state) <u>Severna Park</u> DATE SIGNED <u>2-26-61</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. Holms</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>	22b. DATE THEREOF <u>3-2-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sunset Hill PK</u>	22d. LOCATION (City, town, or county) (State) <u>Brown, Ohio</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>McClary Funeral Home</u> ADDRESS <u>130 E Fort Ave.</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>
		DATE <u>FEB 28 '61</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

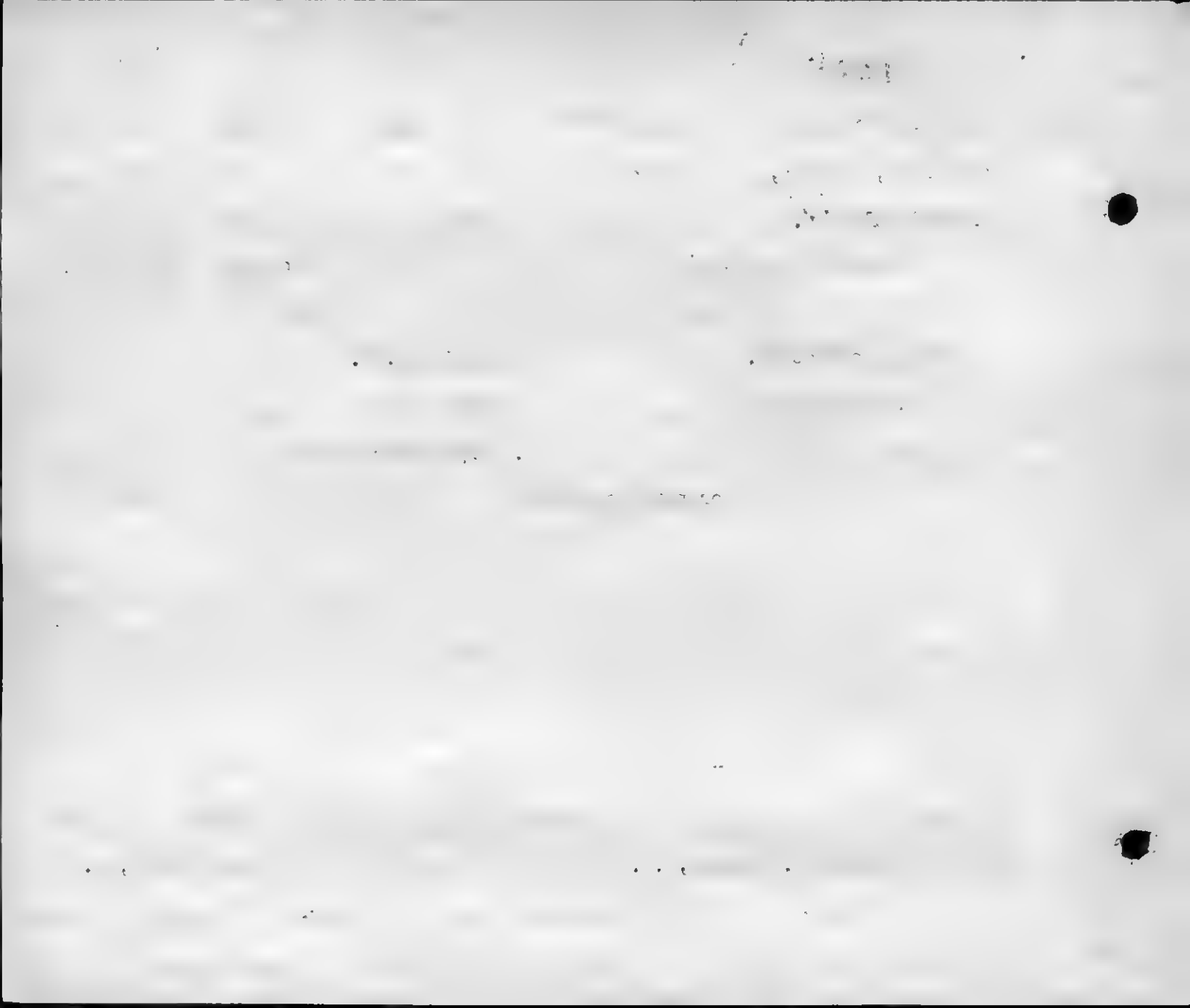
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1481 01461									
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) b. STATE <u>Same</u> c. COUNTY <u>Same</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lake Shore, Pasadena,</u>					c. LENGTH OF STAY IN 1b <u>2 years</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Box 91 Waldo Rd.</u>					d. STREET ADDRESS <u>Same</u>				
3. NAME OF DECEASED (Type or print) <u>James Patrick Maguire</u>					4. DATE OF DEATH <u>February 13 19 61</u>				
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/6/99</u>		9. AGE (In years last birthday) <u>61</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumbing Contractor. Self</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>				
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>Patrick Maguire</u>					14. MOTHER'S MAIDEN NAME <u>Mary Black</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>Mrs. Mary Maguire (wife)</u>				
17. INFORMANT <u>Mrs. Mary Maguire (wife)</u>					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>120.1</u> (a), stating the underlying cause last. DUE TO (c) <u>120.1</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Baltimore</u>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>					CHIEF MEDICAL EXAMINER				
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 2/14/61 DATE SIGNED				
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					Address (Street, city, town, or county) <u>Glen Burnie, Md.</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-17-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
23. FUNERAL DIRECTOR <u>Amey Pickens &amp; Son, Balto 17, Md</u>					24a. REC'D BY REGISTRAR <u>FEB 17 '61</u>				
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>									

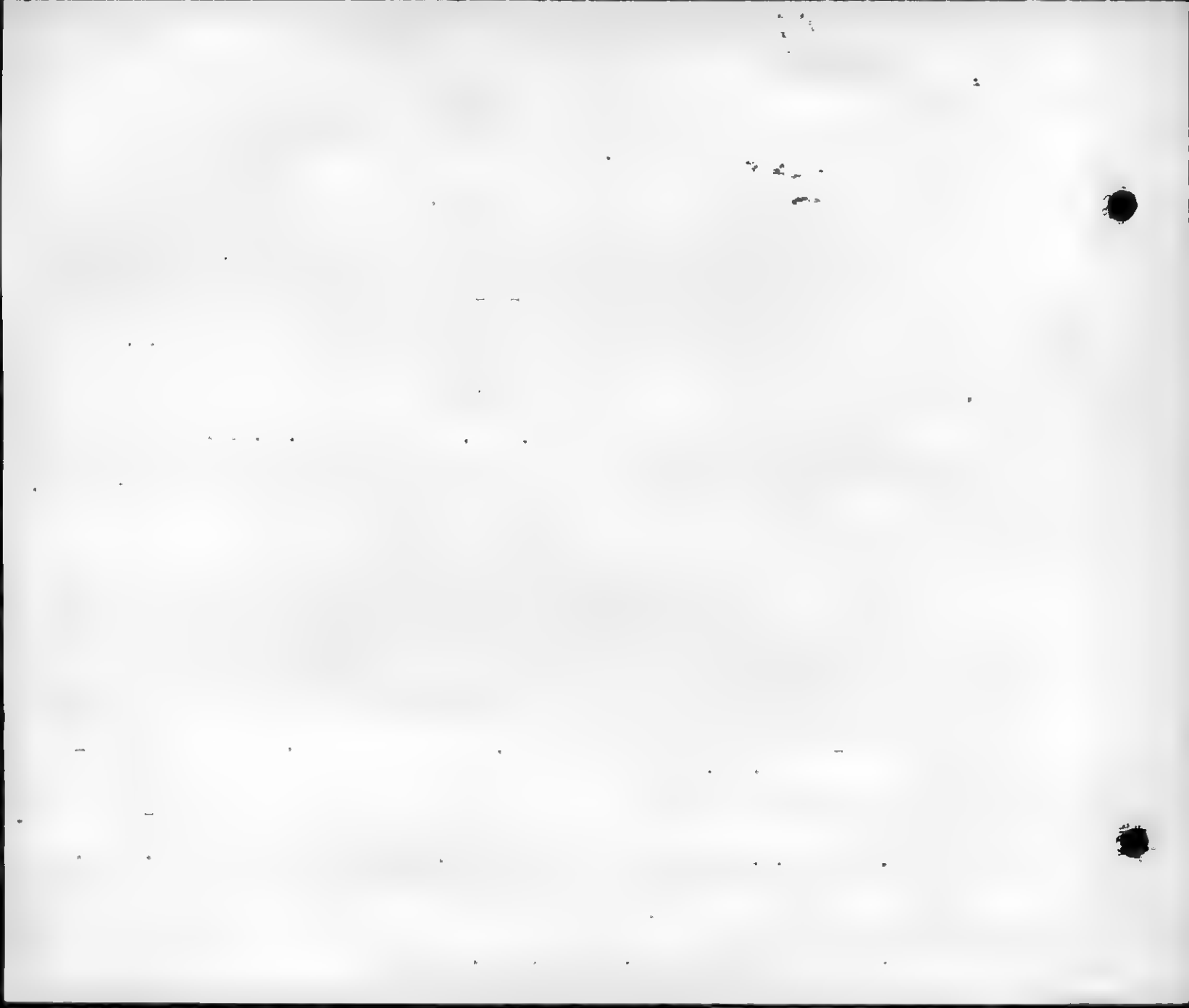


1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
1482  
CERTIFICATE OF DEATH

01462

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 6 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manor Nursing Home				d. STREET ADDRESS 1133 S. Sharp Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Will Maxwell				4. DATE OF DEATH February 21, 1961			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-22-1880		9. AGE (In years last birthday) 80 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Agriculture		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME E. Maxwell				14. MOTHER'S MAIDEN NAME Lillian Smothers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. World War 1 Unknown		17. INFORMANT Mrs. Eliz. Johnson Balto. D.P.W.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH Over 6 yrs.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Feb. 6, 1960, to Feb. 21, 1961, that (I) (we) last saw the deceased alive on Feb. 18, 1961, and that death occurred at 10A M, from the causes and on the date stated above.							
22a. SIGNATURE James M. Pair				22b. DATE SIGNED 2-21-1961		22c. PHYSICIAN'S NAME (Type) James M. Pair, M.D.	
22d. ADDRESS 400 N. Carrollton Avenue Balto. 23, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-23-61		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law				25a. REC'D BY REGISTRAR DATE FEB 23 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



CERTIFICATE OF DEATH

Reg. Dist. No. 01463

1. PLACE OF DEATH a. COUNTY <b>AA</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Ar...</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millersville</b>		c. LENGTH OF STAY IN 1b <b>Brooklyn Glen Burnie</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Knollwood Manor Nur.Hm.</b>		d. STREET ADDRESS <b>22 Georgia Ave,</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Mayers</b> Last <b>Mayers</b>		4. DATE OF DEATH Month <b>2</b> Day <b>4</b> Year <b>1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/8/77</b>
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John Bush</b>		14. MOTHER'S MAIDEN NAME <b>Mary L.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Family</b>	
17. INFORMANT <b>Family</b>		Address <b>Blk</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>AZOTEMIA</b> <b>446X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Nephrosclerosis.</b> DUE TO (c) <b>8 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>8 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>MAY</b> , 19 <b>52</b> to <b>Feb</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>February 2</b> , 19 <b>61</b> , and that death occurred at <b>H.P.</b> M, from the causes and on the date stated above.			
ACTUAL <b>C. McDonald MD</b> M.D.		ADDRESS (Street, city or town, state) <b>Glen Burnie Md</b> DATE SIGNED <b>Feb 6 1961</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>B</b>		22b. DATE THEREOF <b>2/7/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oaklawn</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>McCully Funeral Homes 130 E. Fort Ave.</b>		24a. REC'D BY REGISTRAR <b>FEB 6 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

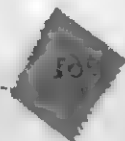
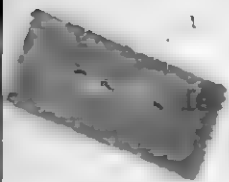
1484

01464

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN TB <b>4 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Riva</b>		d. STREET ADDRESS <b>Riva</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Anne Arundel General Hospital</b>		4. NAME OF DECEASED (Type or print) <b>Abram</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH <b>February 27, 1961</b>		9. AGE (In years last birthday) <b>79</b>		10. IF UNDER 1 YEAR Months <b>24</b> Days <b>10</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>W. Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Mr. Max Mullenax</b>		Address <b>Same As #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> DUE TO <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (b) <b>Unknown</b> (c), stating the underlying cause last. <b>Unknown</b>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)															
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>															
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>															
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)															
20f. (City or town) (County) (State)															
21. I certify that (I) (the hospital) attended the deceased from <b>Feb. 23, 1961</b> to <b>Feb. 27, 1961</b> , that (I) (we) last saw the deceased alive on <b>Feb. 27, 1961</b> , and that death occurred at <b>8:45 A.M.</b> from the causes and on the date stated above.															
22a. SIGNATURE <b>Edward S. Beck</b>															
22b. DATE SIGNED <b>2/27/61</b>															
22c. PHYSICIAN'S NAME (Type) <b>Dr. Edward Beck</b>															
22d. ADDRESS <b>Franklin St., Annapolis, Md.</b>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>															
23b. DATE THEREOF <b>27 March '61</b>															
23c. NAME OF CEMETERY OR CREMATORY <b>Baldwin Church Cem</b>															
23d. LOCATION (City, town or county) (State) <b>Millersville, Md.</b>															
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. G. Singleton</b>															
ADDRESS <b>Glen Burnie, Md.</b>															
25a. REC'D BY REGISTRAR <b>MAR 1 '61</b>															
25b. REGISTRAR'S SIGNATURE <b>Charles S. Hume</b>															

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completed and signed in by the funeral director. After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

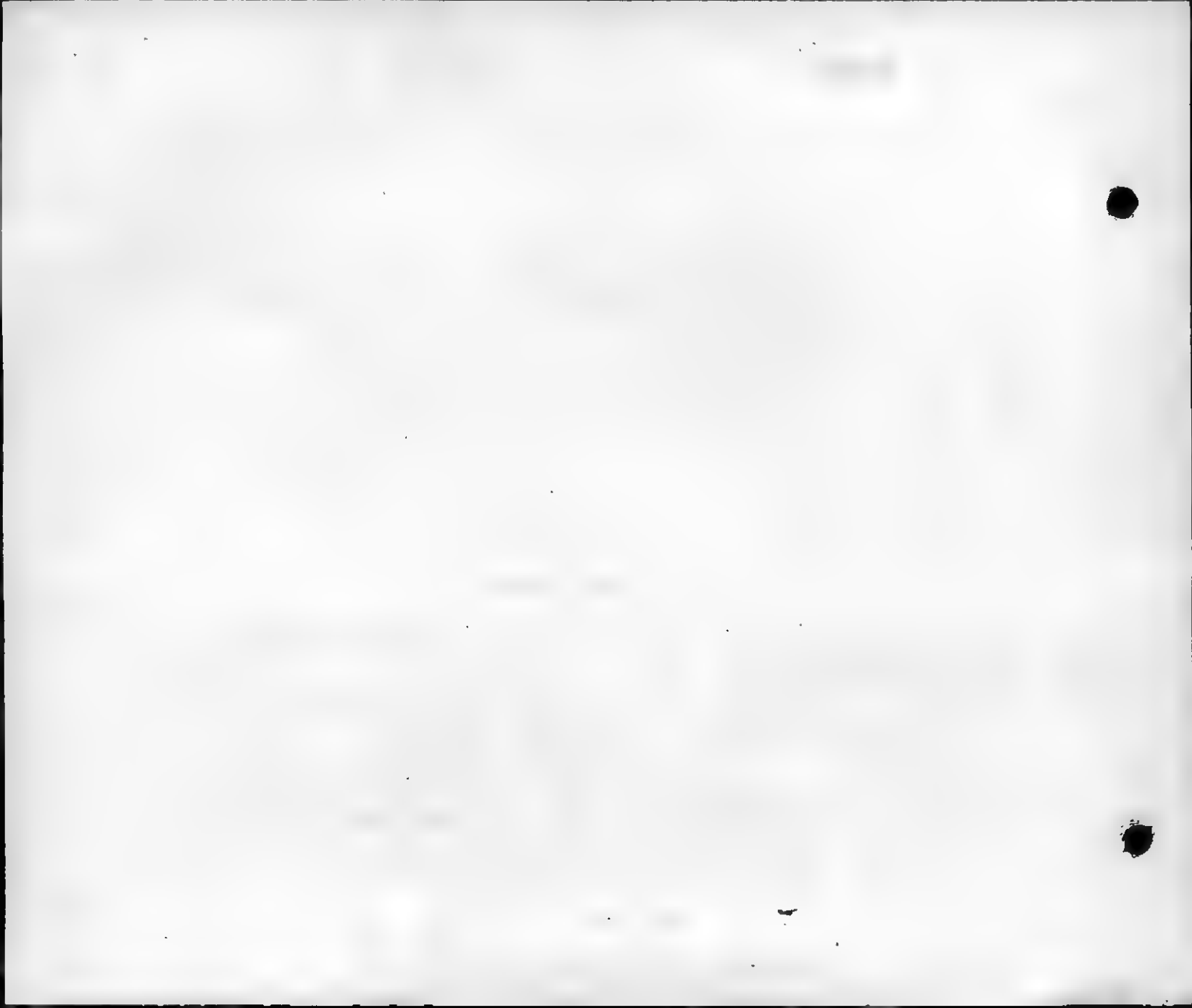
1485

1465

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crownsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
c. LENGTH OF STAY IN 1b <i>5 years 9 mo</i>		d. STREET ADDRESS <i>919 Mc Donough</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Crownsville State Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>Myers</i> Last <i>Myers</i>		4. DATE OF DEATH Month <i>2</i> Day <i>18</i> Year <i>1961</i>	
5. SEX <i>F</i>	6 COLOR OR RACE <i>N</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1906</i>
9. AGE (In years last birthday) <i>54</i> yrs.		IF UNDER 1 YEAR Months <i>3</i> Days <i>18</i> Hours <i>18</i> Min.	IF UNDER 24 HRS Hours <i>18</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Jim Jackson</i>		14. MOTHER'S MAIDEN NAME <i>Nancy —</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Hospital Records (Mrs Laura Foster)</i>		Address <i>—</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>SEPTICEMIA</i>			
103.0 DUE TO <i>DECURBITAL SORES</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>INTRATROCHANTERIC FRACTURE OF L. HIP</i>			
(c) <i>—</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>PSYCHOPHRENIC REACTION - CHRON. UNDIFFERENTIATED TYPE</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>PAT. FELL IN BATH ROOM</i>	
20c. TIME OF INJURY Month. Day. Year Hour o. m. <i>2 12 6</i> 19 <i>61</i> p. m. <i>2</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>CROWNSSVILLE STATE HOSPITAL</i>		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <i>10-17</i> , 19 <i>61</i> , to <i>2-18</i> , 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>2-18</i> , 19 <i>61</i> , and that death occurred at <i>30</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>L. BENEDICT M.D.</i>		22d. ADDRESS <i>CROWNSSVILLE STATE HOSPITAL</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>2/24/61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Calvary Cem.</i>		23d. LOCATION (City, town, or county) (State) <i>A.A. County, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>		25a. REC'D BY REGISTRAR <i>[Signature]</i>	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		DATE <i>FEB 23 '61</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1486

## CERTIFICATE OF DEATH

Reg. Dist. No. 01466

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel County</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>a. a.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millersville,</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Knollwood Manor Nursing Home</b>				d. STREET ADDRESS <b>Rock Creek Park</b>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>M.</b> Last <b>Nicholson</b>				4. DATE OF DEATH Month <b>February</b> Day <b>5</b> Year <b>1961</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 17, 1875</b>		9. AGE (In years last birthday) <b>85</b> yrs	IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Culver, Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>unknown</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>212-22-8293</b>		17. INFORMANT Address <b>Mrs. Bertha M. Martin, Rock Creek Park, Pasadena, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebral infarction</b> DUE TO <b>32</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arterio sclerosis of cranial vessels</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>coronary artery disease, hypertension</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>? dual</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour <b></b> a. m. <b></b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/21</b> , 19 <b>60</b> , to <b>2/5</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>2/1</b> , 19 <b>61</b> , and that death occurred at <b>2:40 a. m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>121 CHATELAIN ST ANNAPOLIS</b> DATE SIGNED <b>2/5/61</b>							
ACTUAL SIGNATURE <b>George A. Church M.D.</b>		PHYSICIAN'S NAME (Type) <b>GEORGE A. CHURCH M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2-7-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street, Baltimore</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 9 '61</b>		24b. REGISTRAR'S SIGNATURE <b>John S. Tinsley</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

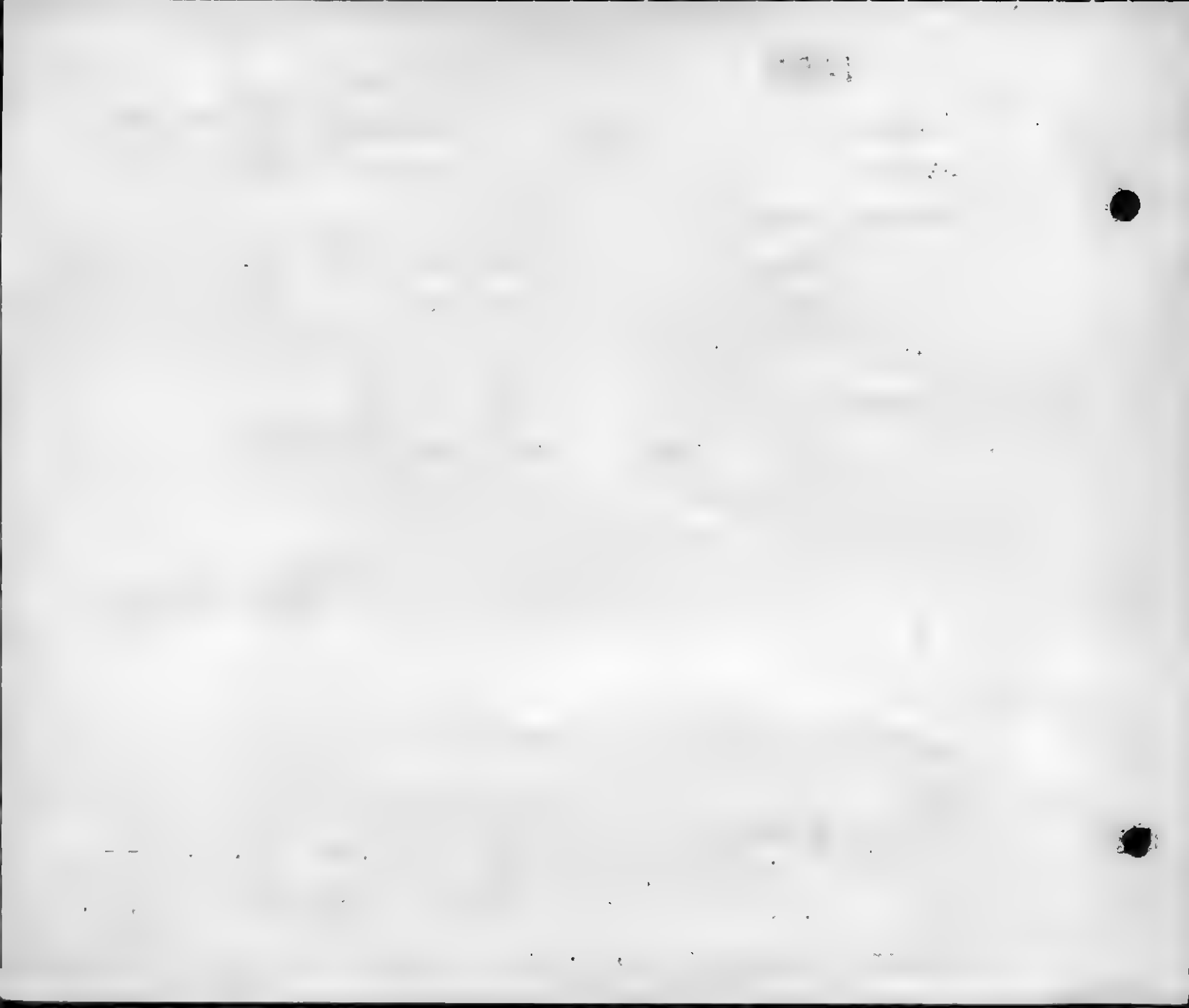
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1487

01467

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN lb <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Herald Harbor Crownsville</u> d. STREET ADDRESS <u>X</u>		<b>3. NAME OF DECEASED</b> (Type or print) First <u>Elsmere</u> Middle <u>Northrup</u> Last <u>Feb.</u>		<b>4. DATE OF DEATH</b> Month <u>4</u> Day <u>19</u> Year <u>61</u>									
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>April 5, 1880</u>		<b>9. AGE</b> (In years last birthday) <u>80</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>11. IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Salesman</u>				<b>11. BIRTHPLACE</b> (County & State or foreign country) <u>Nova Scotia</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>Unknown</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>				<b>16. SOCIAL SECURITY NO.</b> <u>Unknown</u>			
<b>17. INFORMANT</b> <u>Personal Papers of Deceased</u>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> 332 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>CEREBRAL ARTERIO SCLEROSIS</u> (c) <u>  </u> DUE TO (e), stating the underlying cause last.				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>3 DAYS</u>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e)</b> <u>PREVIOUS CEREBRAL THROMBOSES</u>												<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>  </u> e.m. <u>  </u> p.m. <u>  </u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. City or town</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from <u>2-1</u> 19<u>61</u>, to <u>2-4</u> 19<u>61</u>, that (I) (we) last saw the deceased alive on <u>2/3</u> 19<u>61</u>, and that death occurred at <u>6:30</u> M, from the causes and on the date stated above.</b>															
<b>22a. SIGNATURE</b> <u>Edward S. Beck</u>				<b>22b. PHYSICIAN'S NAME (Type)</b> <u>Edward S. Beck</u>				<b>22c. ADDRESS</b> <u>Franklin St. Annapolis, Md. 2-4-61</u>				<b>22d. DATE SIGNED</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>Feb. 7, 61</u>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Fort Lincoln Cemetery</u>				<b>23d. LOCATION</b> (City, town or county) (State) <u>Prince George County, Md.</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Hopping Funeral Home</u>				<b>24b. ADDRESS</b> <u>Annapolis, Md.</u>				<b>25a. REC'D BY REGISTRAR</b> <u>FER 8 '61</u>				<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hanes</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, removal, and in any event, within 72 hours after death.

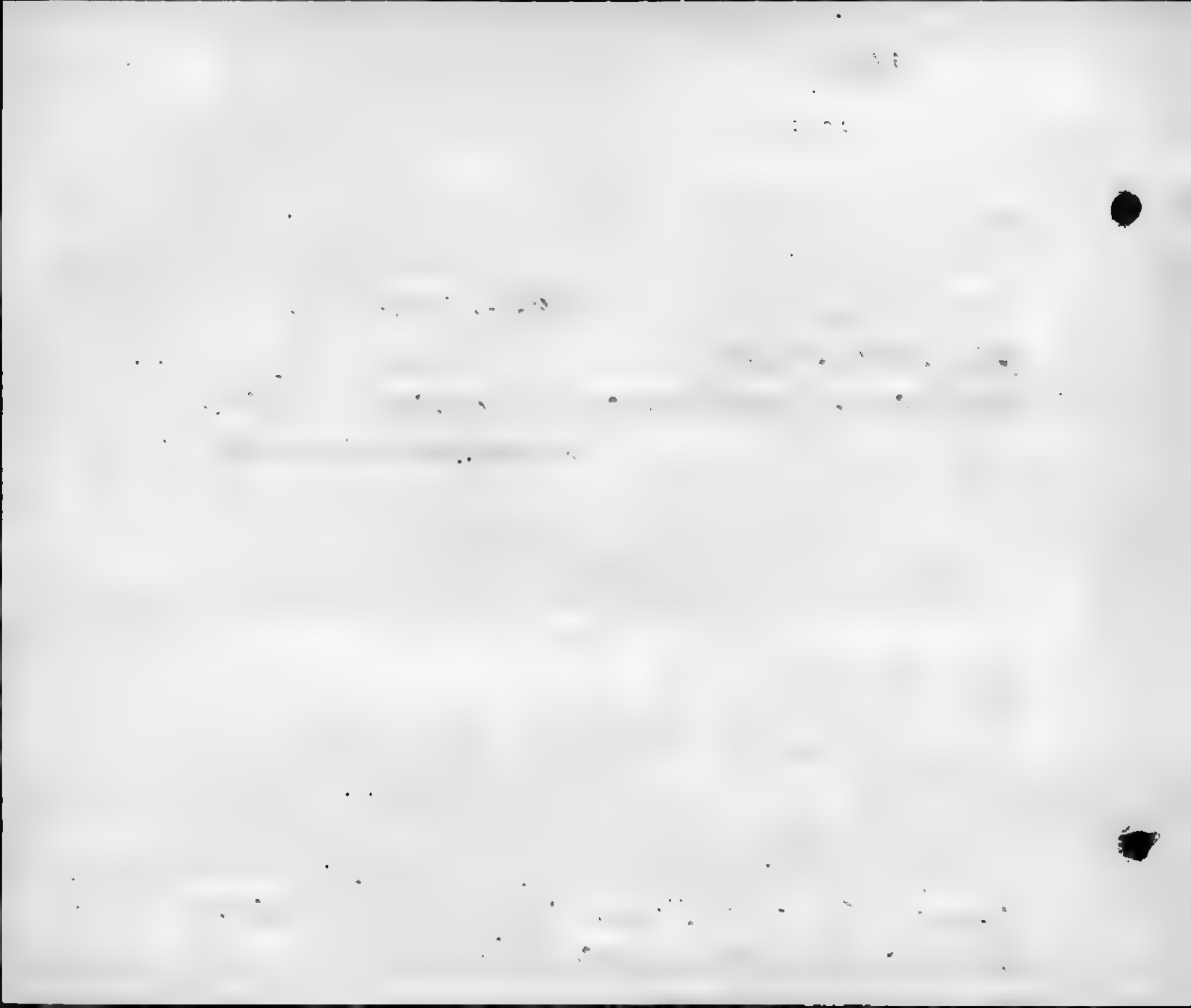
VR A15 (4)  
15M 9/110

1488

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01468

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence Before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>89 Charles St.</u>	
3. NAME OF DECEASED (Type or print) <u>Annie</u>		4. DATE OF DEATH Month <u>February</u> Day <u>13</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-6-1886</u>
9. AGE (in years last birthday) <u>74</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William A. Henderson</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Carr</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Sarah Green 108 South Street</u>	
17. INFORMANT <u>Sarah Green 108 South Street</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Liver Disease</u> DUE TO <u>3X</u> Conditions, if any, which gave rise to immediate cause (b) <u>3X</u> (c) <u>3X</u> DUE TO <u>3X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). <u>Heart Disease</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Heart Disease</u>	
21. I certify that (I) (doctored) attended the deceased from <u>Feb 13 1961</u> to <u>Feb 13 1961</u> ; that (I) (doctored) last saw the deceased alive on <u>Feb 13 1961</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.		22. SIGNATURE <u>Faye W. Allen</u> M.D. <u>XX</u>	
22a. PHYSICIAN'S NAME (Type) <u>Faye W. Allen</u>		22b. DATE SIGNED <u>2/14/61</u>	
22c. ADDRESS <u>62 Cathedral St., Annapolis, Md.</u>		22d. ADDRESS <u>62 Cathedral St., Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-17-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		23d. LOCATION (City, town or county) <u>Annapolis Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Beesett</u>		25a. REC'D BY REGISTRAR <u>Feb 15 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur J. House</u>		25c. REGISTRAR'S SIGNATURE <u>Arthur J. House</u>	



## CERTIFICATE OF DEATH

01469

Reg. Dist. No. ....

1489

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>AA</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>2</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Severna Pk.</b>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Severna Park</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>500 Hodges Lane</b>				STREET ADDRESS (If rural give location) <b>500 Hodges Lane</b>			
3. NAME OF DECEASED (Type or Print) <b>HAZEL J. PFEIFFER</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>FEB 7 19 61</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>M</b>	8. DATE OF BIRTH <b>5/21/05</b>		9. AGE last birthday <b>55</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>N.J.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Adolph Burkhardt</b>				14. MOTHER'S MAIDEN NAME <b>Emily Kramer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <b>Family Spme</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <b>Acute pulmonary oedema</b>				INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b>			
ANTECEDENT CAUSE(S) DUE TO (B) <b>Mitral stenosis</b>				<b>Years</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <b>Rheumatic fever.</b>				<b>Years.</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>1/21</b> , 19 <b>61</b> , to <b>2/7</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>2/7</b> , 19 <b>61</b> , and that death occurred at <b>12</b> M., from the causes and on the date stated above.							
SIGNATURE <b>Gerard Church</b>				M.D. <b>121 Catholic St. An. of 15th 3/1/61</b>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>B</b>		DATE THEREOF <b>2/10/61</b>		NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cem.</b>		LOCATION (City, town, or county) (State) <b>Glen Burnie, Md/</b>	
24. REC'D BY REGISTRAR DATE <b>FEB 9 '61</b>		REGISTRAR'S SIGNATURE <b>C. S. Jones</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>McCully Funeral Homes 130 E. Fort Ave.</b>			

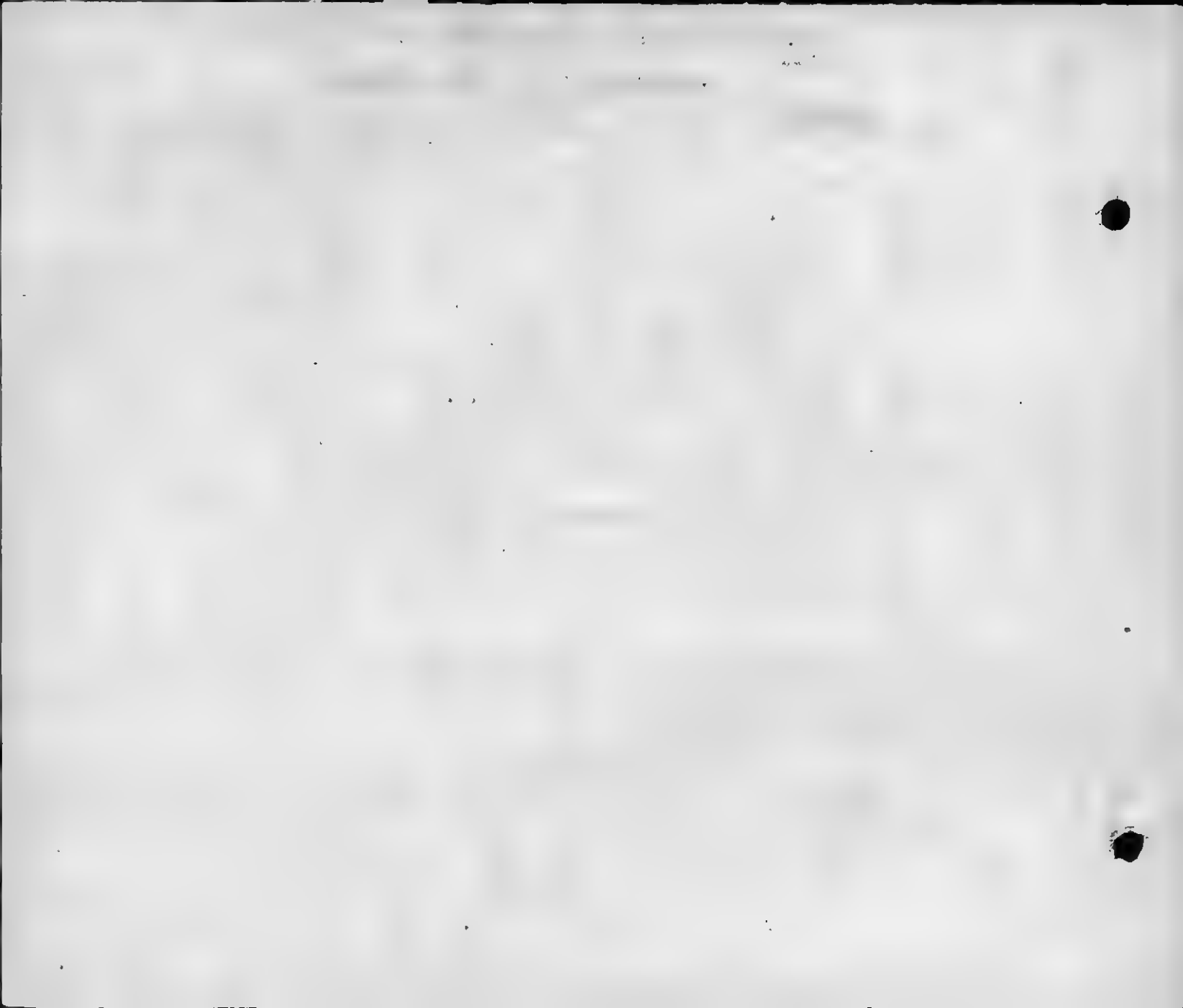
INSTRUCTIONS

**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial permit.

VS A15C 1-55-10M



1490

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

01470

1. PLACE OF DEATH a. COUNTY <i>A. A.</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> c. LENGTH OF STAY IN 1b <i>1</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>167 King Geo St</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>A. A.</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> d. STREET ADDRESS <i>167 King Geo St</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Catherine E.</i> Middle <i>Popham</i> Last <i>Popham</i>		4. DATE OF DEATH Month <i>2-</i> Day <i>7-</i> Year <i>1961</i>	
5. SEX <i>F.</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-14-1883</i>
9. AGE (In years last birthday) <i>77</i> yrs.		10. IF UNDER 1 YEAR Months <i>7</i> Days <i>1</i>	11. IF UNDER 24 HRS Hours <i>1</i> Min <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unemployed</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Unemployed</i>	
11. BIRTHPLACE (State or foreign country) <i>Annapolis, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Leonard B Popham</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Holland</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Mrs Joseph T. Meekins</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute cardiac Dehydration</i> (b) <i>Artificially - Cardio-Vascular</i> (c) <i>Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>222</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>2/6/61</i> to <i>2/7/61</i> 19 <i>61</i> that (I) (we) last saw the deceased alive on <i>2/6/61</i> and that death occurred on <i>2/7/61</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Arthur S. Kneass</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <i>Annapolis, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <i>2-9-1961</i>	23c. NAME OF CEMETERY OR CREMATORY <i>St Annes Cent</i>	23d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		25a. RECORD BY REGISTRAR <i>Arthur S. Kneass</i>	
ADDRESS <i>Annapolis Md</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kneass</i>	
DATE <i>FEB 14 61</i>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

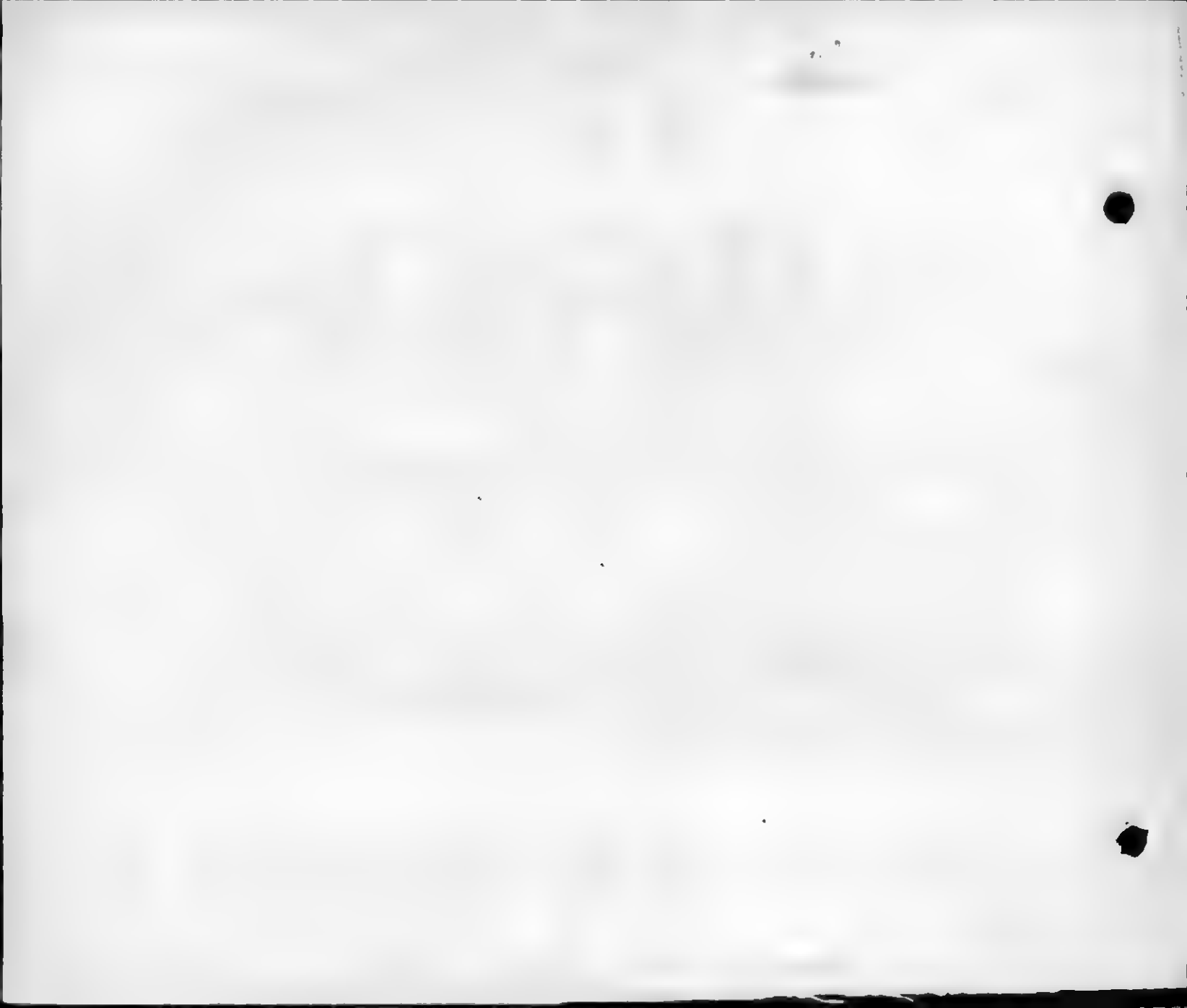
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 01471

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Annapolis</u>	
c. LENGTH OF STAY IN 16 <u>SEVERAL YEARS</u>		d. STREET ADDRESS <u>1 Cape St Claire</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cape St Claire</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Perry</u> First <u>A</u> Middle <u>PLUGH</u> Last		4. DATE OF DEATH Month <u>2</u> Day <u>25</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-12-1904</u>
9. AGE (In years last birthday) <u>56</u> yrs		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D. S. LAY, WILMINGTON, VT.</u>	
11. BIRTHPLACE (State or foreign country) <u>VT.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry J. Plugh</u>		14. MOTHER'S MAIDEN NAME <u>Leta Cole</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>517-108413</u>	
17. INFORMANT <u>Jenna</u>		Address <u>Cape St Claire</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> 3 4 5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic myocarditis</u> (c) <u>Multiple sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>35 hours</u> <u>Several years</u> <u>12 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-38</u> , 19 <u>59</u> to <u>2-25</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>2-25</u> , 19 <u>61</u> , and that death occurred at <u>6:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bernard C.R. Galt</u> M.D.		ADDRESS (Street, city or town, state) <u>Cape St Claire Rt 4</u> DATE SIGNED <u>2/25/61</u>	
PHYSICIAN'S NAME (Type) <u>Bernard C.R. GALT</u>		<u>Annapolis Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>2-28-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Ignace</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Lawrence</u> ADDRESS <u>Severna Park</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 28 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>  </u>	





1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

01472

1492 Item 11 Film 6282 3-4-61 et

1. PLACE OF DEATH  
a. COUNTY Anne Arundel MARYLAND  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Laurel  
c. LENGTH OF STAY IN 1b 2 mons  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Tackroom Brn 14 Laurel Racetrack

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE D.C.  
b. COUNTY Washington  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 4423 Kane Place N.E.  
d. STREET ADDRESS 4423 Kane Place N.E.

3. NAME OF DECEASED (Type or print) Alfred Holcomb Pumphrey  
4. DATE OF DEATH February 22 19 61  
5. SEX Male 6. COLOR OR RACE C 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH Aug 22 1912  
9. AGE (In years last birthday) 48 yrs. 10. IF UNDER 1 YEAR Months Days Hours Min. 11. BIRTHPLACE (State or foreign country) City of Washington, D.C. 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Richard Pumphrey 14. MOTHER'S MAIDEN NAME Mary Etta Ross  
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW2 16. SOCIAL SECURITY NO. 577-12-0777 17. INFORMANT Mrs Ester Brown Address 4423 Kane Pl NE

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Coronary Occlusion  
420.1 DUE TO  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420.1  
DUE TO (c)  
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) Sudden

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

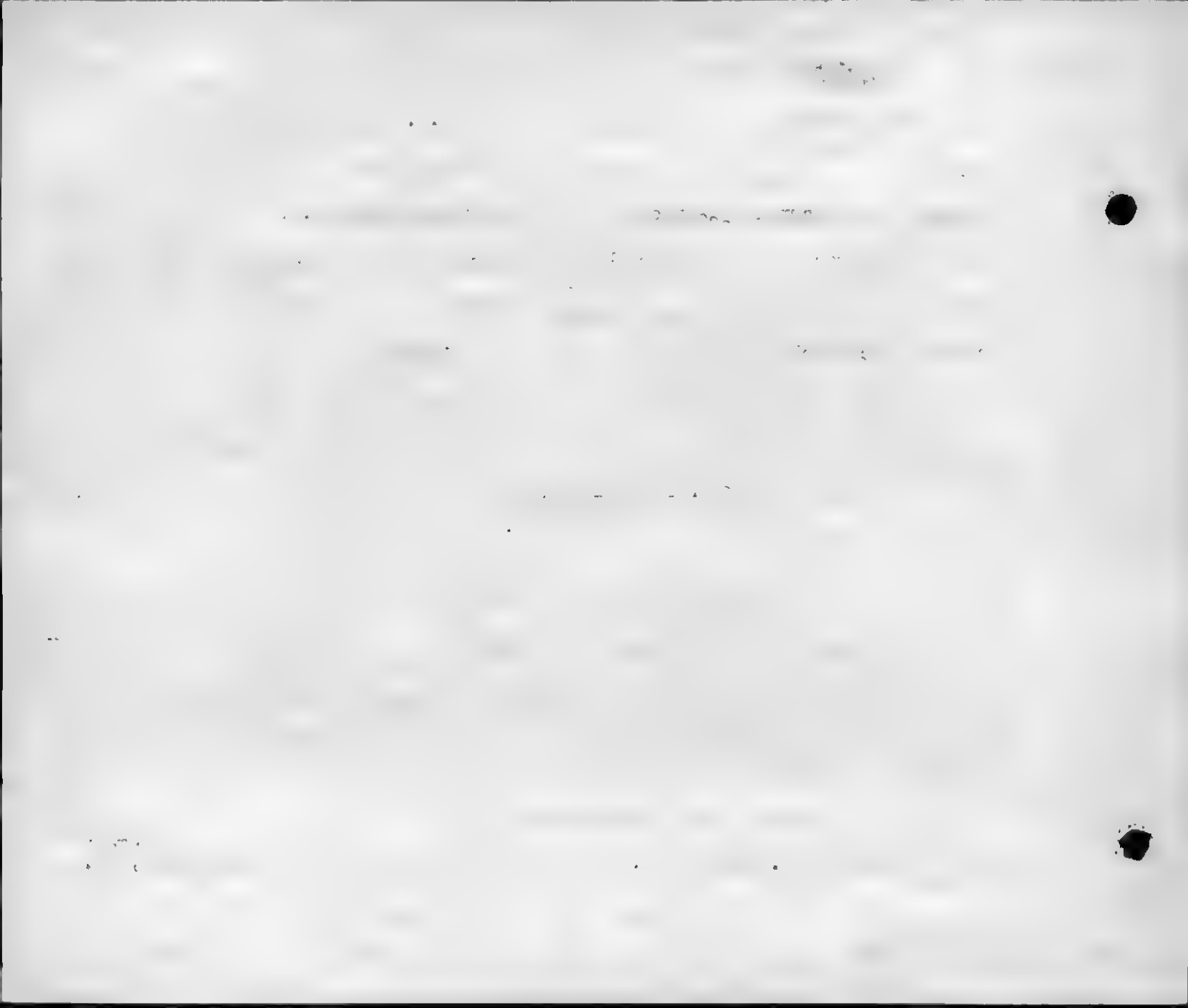
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Gustave H. Faubert MD CHIEF MEDICAL EXAMINER ☐  
EXAMINER'S NAME (Type) Gustave H. Faubert MD M.D. ASSISTANT MEDICAL EXAMINER ☐  
DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 2-22-61  
Address (Street, city, town, or county) Glen Burnie, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) 2-27-61 22b. DATE THEREOF Baltimore Md 22c. NAME OF CEMETERY OR CREMATORY Baltimore Md 22d. LOCATION (City, town, or country) (State) Baltimore Md

23. FUNERAL DIRECTOR Henry S. Washington & Son ADDRESS 4925 Maine Ave NE 24a. REC'D BY REGISTRAR. DATE FEB 28 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas

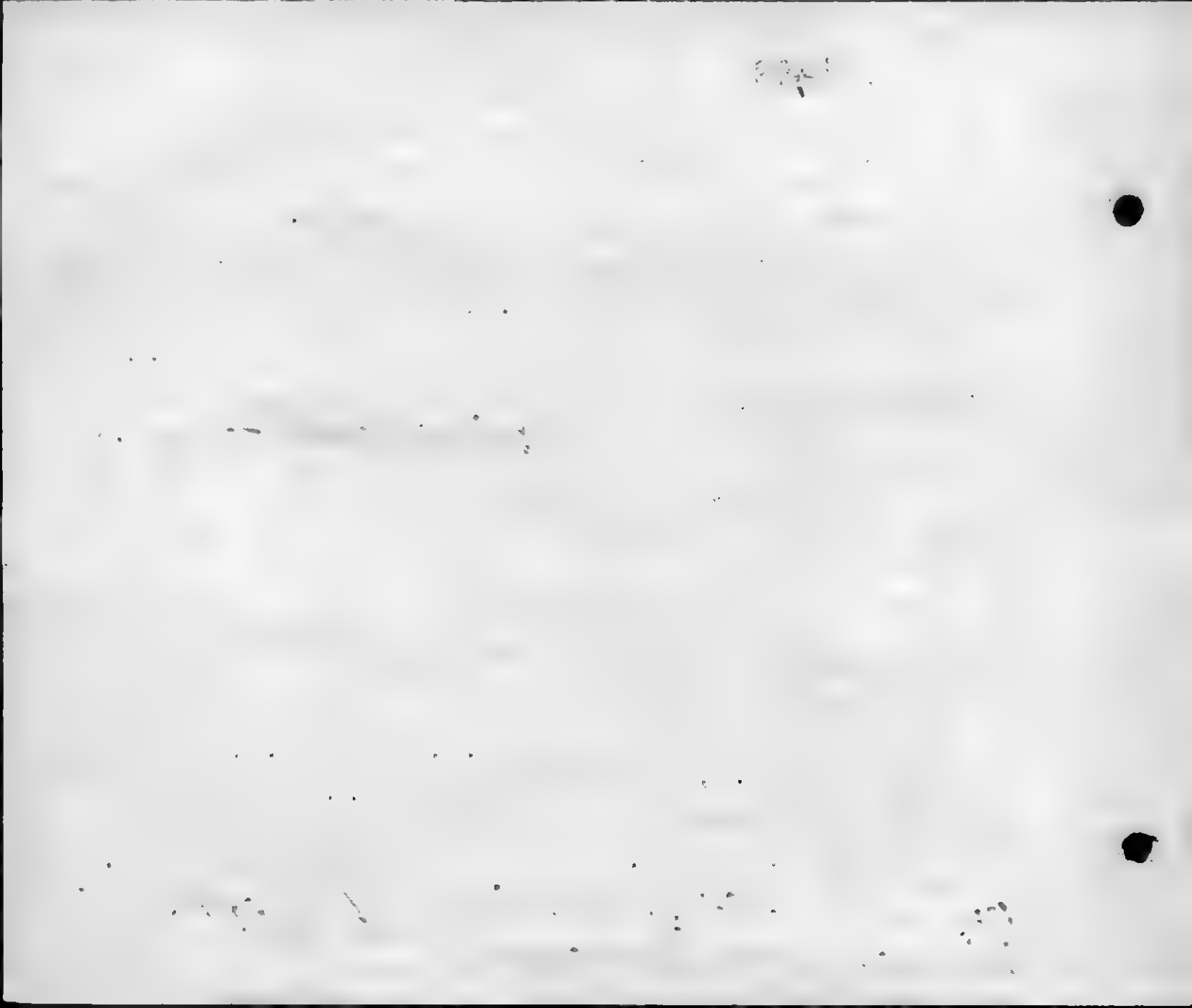


1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician and completely removed by the funeral director. After this certificate has been signed by the attending physician and completely removed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
1493  
CERTIFICATE OF DEATH

01473

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN 1b <b>11 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> d. STREET ADDRESS <b>35 Hicks Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lorraine (none) RANDALL</b>		4. DATE OF DEATH <b>February 7 1961</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 5, 1961</b>	
9. AGE (In years last birthday) <b>1</b>		10. IF UNDER 1 YEAR <b>1</b> IF UNDER 24 HRS. <b>11 25</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Oliver Franklin RANDALL</b>	
14. MOTHER'S MAIDEN NAME <b>Katherine Delores Blake</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>776 X</b>		17. INFORMATION <b>Oliver F. Randall 35 Hicks Ave Hospital records</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Immaturity - Prematurity</b> DUE TO (b) <b>776 X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>30 hr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Annapolis</b> (County) <b>Anne Arundel</b> (State) <b>Md.</b>		21. I certify that (I) (the deceased) attended the deceased from <b>Feb. 5, 1961</b> , to <b>Feb. 7, 1961</b> , that (I) (XX) last saw the deceased alive on <b>Feb. 7, 1961</b> , and that death occurred at <b>10:50 A.M.</b>	
22a. SIGNATURE <b>James I. Hudson, Jr.</b>		22b. DATE SIGNED <b>Feb. 7, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>James I. Hudson, Jr.</b>		22d. ADDRESS <b>River Club Estates, Edgewater, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-14-1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Brewer Hill</b>		23d. LOCATION (City, town or county) <b>Annapolis Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>William Beese</b>		25a. REC'D BY REGISTRAR <b>FEB 15 1961</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Adams</b>		25c. DATE	

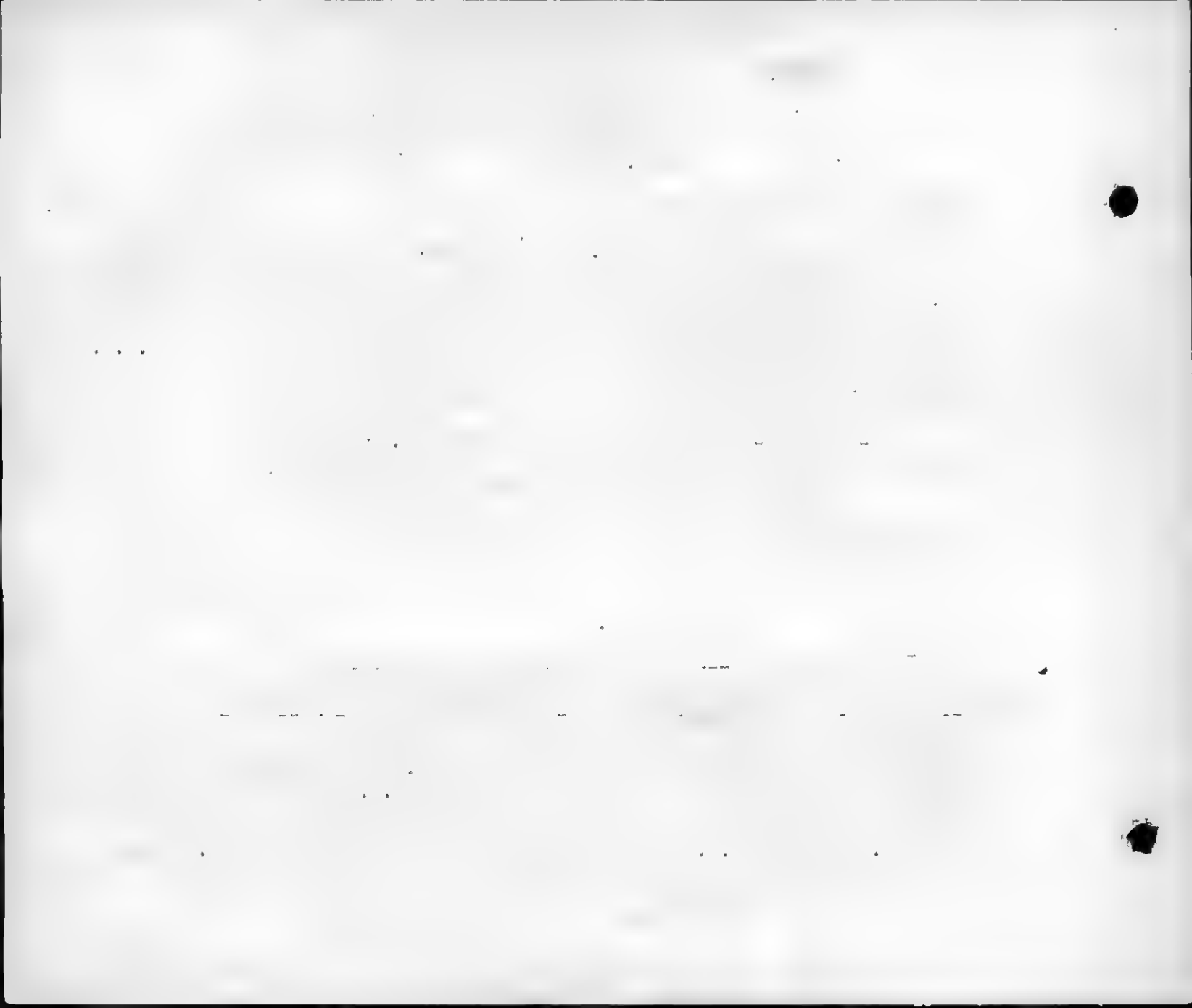


1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01475

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>R.</b> Last <b>Roberts</b>		4. DATE OF DEATH Month <b>2</b> Day <b>12</b> Year <b>19 61</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1900</b>
9. AGE (In years last birthday) <b>60 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Roberts</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>Unknown</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diabetes Mellitus 260</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>100X</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenia, Hebephrenic 300.1</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>How</b> <b>19</b> p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8/23/19 27</b> to <b>2/12/19 61</b> , that (I) (we) last saw the deceased alive on <b>2/12/19 61</b> , and that death occurred at <b>4:30 A.M.</b> from the causes and on the date stated above			
22a. SIGNATURE <b>L. Benedict, M.D.</b>		22b. DATE SIGNED <b>2/14/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M.D.</b>		22d. ADDRESS <b>Crownsville State Hospital. Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>24 Feb-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cen. of Md.</b>		23d. LOCATION (City, town, or county) (State) <b>Balt. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Reese II</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 24 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		25c. ADDRESS <b>108 W. Wash. St. Ann. Md.</b>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completed and signed by the funeral director. After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

1  
M  
I  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
1497  
01476  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN b <b>7 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Crownsville State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3003 Cherryland Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Annie Robinson</b> First Middle Last 4. DATE OF DEATH <b>2 27 1961</b> Month Day Year		5. SEX <b>Female</b> 6. COLOR OR RACE <b>Negro</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>1906?</b> 9. AGE (In years last birthday) <b>55?</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b> 11. BIRTHPLACE (Country & State, or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Unknown</b> 14. MOTHER'S MAIDEN NAME <b>Unknown</b> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> 16. SOCIAL SECURITY NO <b>Unknown</b> 17. INFORMANT <b>Hospital Records</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO <b>Glomerulonephritis Acute</b> Conditions, if a, which gave rise to immediate cause (e), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Syphilitic Aortitis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <b>2/20 1961</b> Hour a.m. p.m. <b>4:30 a.m.</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>2/20 1961</b> to <b>2/27 1961</b> , that (I) (we) last saw the deceased alive on <b>2/27 1961</b> , and that death occurred at <b>4:30 a.m.</b> from the causes and on the date stated above.	
22a. SIGNATURE <b>L. Benedict, M.D.</b> 22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M.D.</b>		22b. DATE SIGNED <b>2/27/61</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Mar 4/61 Mt Calvary</b> 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) <b>Baltimore</b>		25. REC'D BY REGISTRAR <b>Mar 3 '61</b> 26. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

2001

0 3 9

0 0

0 0

9



TO DEF. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please ex- this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

FOR STATE  
HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 1493 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01472

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>211 Millicent Ave.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>AA</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u> d. STREET ADDRESS <u>1 211 Millicent St Cor.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Henry</u> First Middle Last 4. DATE OF DEATH <u>Feb 5 1961</u> Month Day Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>2/13/05</u> 9. AGE (In years last birthday) <u>55</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours M.n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Surgeon</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Army</u> 11. BIRTHPLACE (State or foreign country) <u>Ind.</u> 12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Geo.</u> 14. MOTHER'S MAIDEN NAME <u>?</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>Family</u> 17. INFORMANT <u>Family</u> Address <u>Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Subarachnoid Hemorrhage</u> <u>33 OX</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rupture of Aneurysm of Blood vessel of Brain</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>William J. Gandy</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>FEB 5 1961</u> DATE SIGNED DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>2/9/61</u> 22b. DATE TIME OF 22c. NAME OF CEMETERY OR CREMATORY <u>Woodlands</u> 22d. LOCATION (City, town, or country) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR <u>John E. Taylor</u> ADDRESS 24a. REC'D BY REGISTRAR <u>FEB 6 1961</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

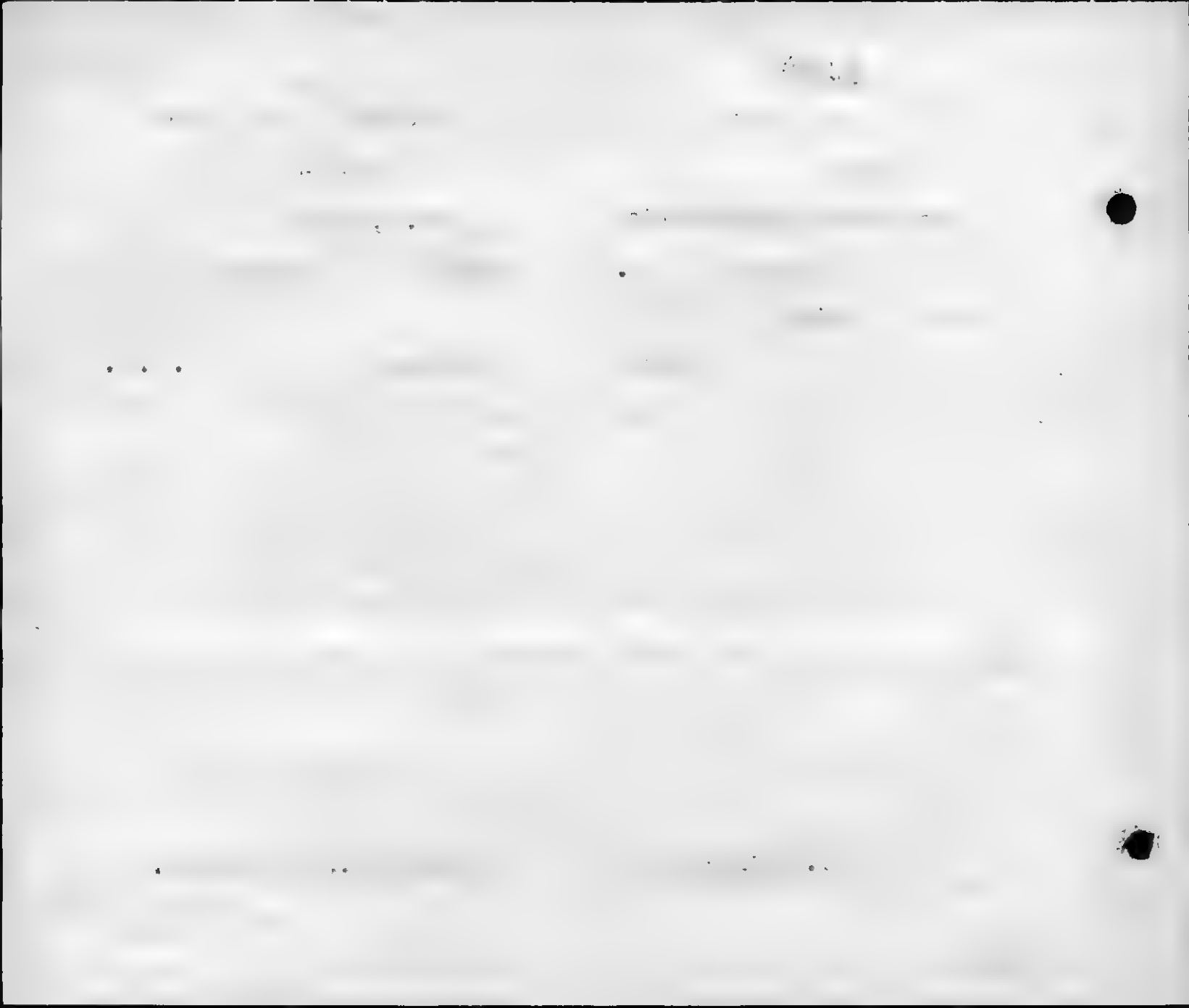
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1498

01477

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewater</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>Rt. 2, Box 213E</b>	
3. NAME OF DECEASED (Type or print) <b>Charles M. Russell</b>		DATE OF DEATH <b>February 2, 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG 18 - 1879</b>
9. AGE (In years, last birthday) <b>81</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machineist</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William J. Russell</b>		14. MOTHER'S MAIDEN NAME <b>Henrietta Eisenratt</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Retired U.S. A.</b>		16. SOCIAL SECURITY NO. <b>Anna M. Russell</b>	
17. INFORMANT <b>Anna M. Russell</b>		18. CRUISE OF DEATH (Enter only one cause per line for (a), (b), and (c).) ART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO Cause, if any, which gave rise to immediate cause (b) <b>Carcinoma of Prostate</b> (a), stating the underlying cause last. (c)	
19. INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occurred at.....M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Edwin Davis</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>Cathedral St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-5-1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Bluff Cemt</b>		23d. LOCATION (City, town or county) (State) <b>Annapolis Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor Sons</b>		25a. REC'D BY REGISTRAR <b>FEB 6 '61</b>	
ADDRESS <b>Annapolis Md</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Brand</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. If the deceased was in the hospital or attended by a physician, the certificate should be filled in by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

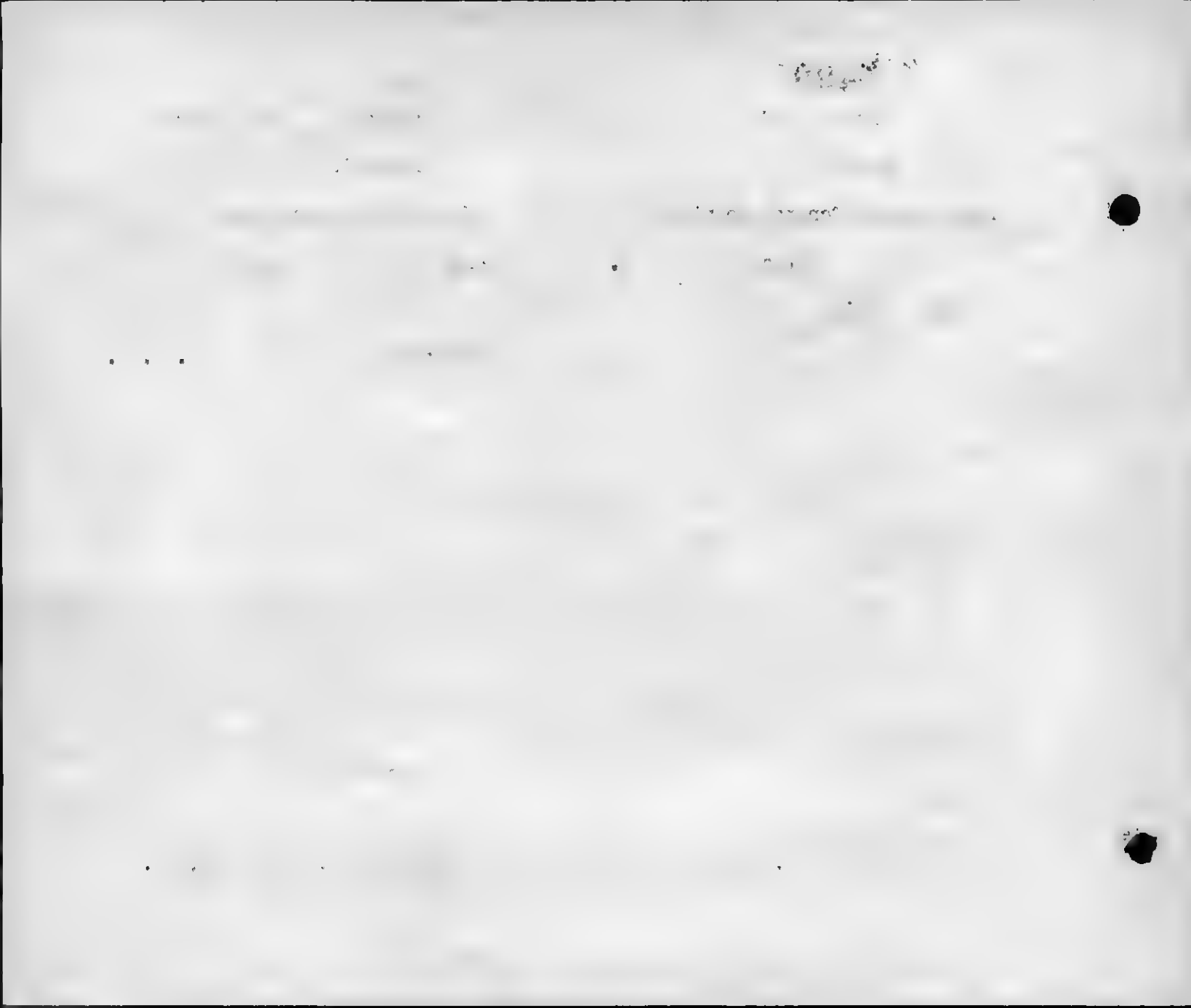
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01478

1499

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN town d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> d. STREET ADDRESS <b>316 North Glenn Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Norman A. Sands</b>		4. DATE OF DEATH <b>February 11 1961</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 23, 1903</b>	
9. AGE (in years last birthday) <b>57 yrs.</b>		10. IF UNDER 1 YEAR: Months <b>57</b> Days <b>11</b> Hours <b>19</b> Min. <b>61</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pipefitter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Naval Station</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas Sands</b>		14. MOTHER'S MAIDEN NAME <b>Effie M. Freeman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b>	
17. ADDRESS <b>Louise Sands #2</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY HEMORRHAGE</b> DUE TO (b) <b>CARCINOMA OF LUNG</b> DUE TO (c) <b>DIABETES MELLITUS</b>	
19. INTERVAL BETWEEN ONSET AND DEATH <b>1 HOUR</b>		20. 9 MONTHS	
21. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIABETES MELLITUS</b>		22. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		23b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
24a. TIME OF INJURY Month, Day, Year <b>19</b>		24b. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
24c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		24d. (City or town) (County) (State)	
25. I certify that (I) (the undersigned) attended the deceased from <b>2/8</b> 19 <b>61</b> to <b>2/11</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>2/10</b> 19 <b>61</b> , and that death occurred <b>4:25AM</b> from the causes and on the date stated above.		26. SIGNATURE <b>Edward S. Beck</b> M.D. <b>2/12/61</b>	
27a. PHYSICIAN'S NAME (Type) <b>Edward S. Beck</b>		27b. DATE SIGNED <b>2/12/61</b>	
28a. REC'D BY REGISTRAR <b>FEB 14 '61</b>		28b. REGISTRAR'S SIGNATURE <b>Arthur S. ...</b>	
29a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		29b. DATE THEREOF <b>2-15-1961</b>	
29c. NAME OF CEMETERY OR CREMATORY <b>Cedar Bluff</b>		29d. LOCATION (City, town or county) (State) <b>Annapolis Md.</b>	
30. FURNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor &amp; Sons</b>		30. ADDRESS <b>Annapolis, Md.</b>	



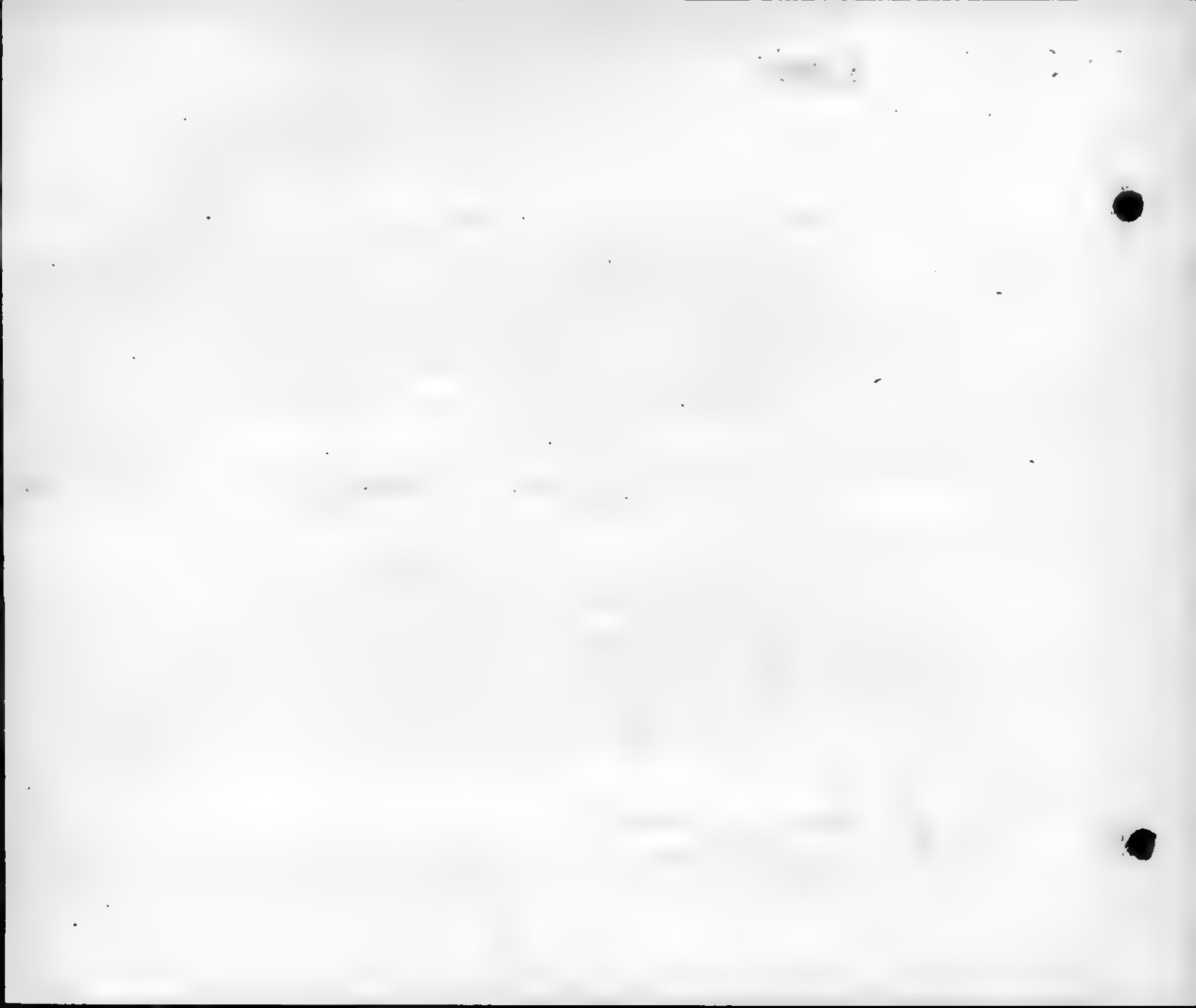
may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

01479

1500

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 122-Rt. 11</u>				d. STREET ADDRESS <u>Box 122-Rt. 11 - Powhatan Beach</u>			
3. NAME OF DECEASED (Type or print) First <u>Warren</u> Middle <u>T.</u> Last <u>Shawen</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>28</u> Year <u>1941</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7 Aug. 1903</u>	
9. AGE (In years last birthday) <u>37</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>B.O.-R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Harris T. Shawen</u>			
14. MOTHER'S MAIDEN NAME <u>Clara K. Kimball</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>213-011750</u>				17. INFORMANT <u>Evelyn M. Shawen - Same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Leukemia - Chronic</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that (I) (this hospital) attended the deceased from <u>2/24</u> 19 <u>41</u> to <u>2/28</u> 19 <u>41</u> , that (I) (we) last saw the deceased alive on <u>2/24</u> 19 <u>41</u> , and that death occurred at <u>8:45 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>J. Brady Smith</u> M.D.				22b. DATE SIGNED <u>3/1/41</u>			
22c. PHYSICIAN'S NAME (Type) <u>J. BRADY SMITH</u>				22d. ADDRESS <u>Pasadena Beach, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3 March-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town, or county) <u>Brockton</u> (State) <u>Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Brighton - Glen Burnie, Md.</u>				25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
DATE <u>MAR 6 '61</u>							





HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

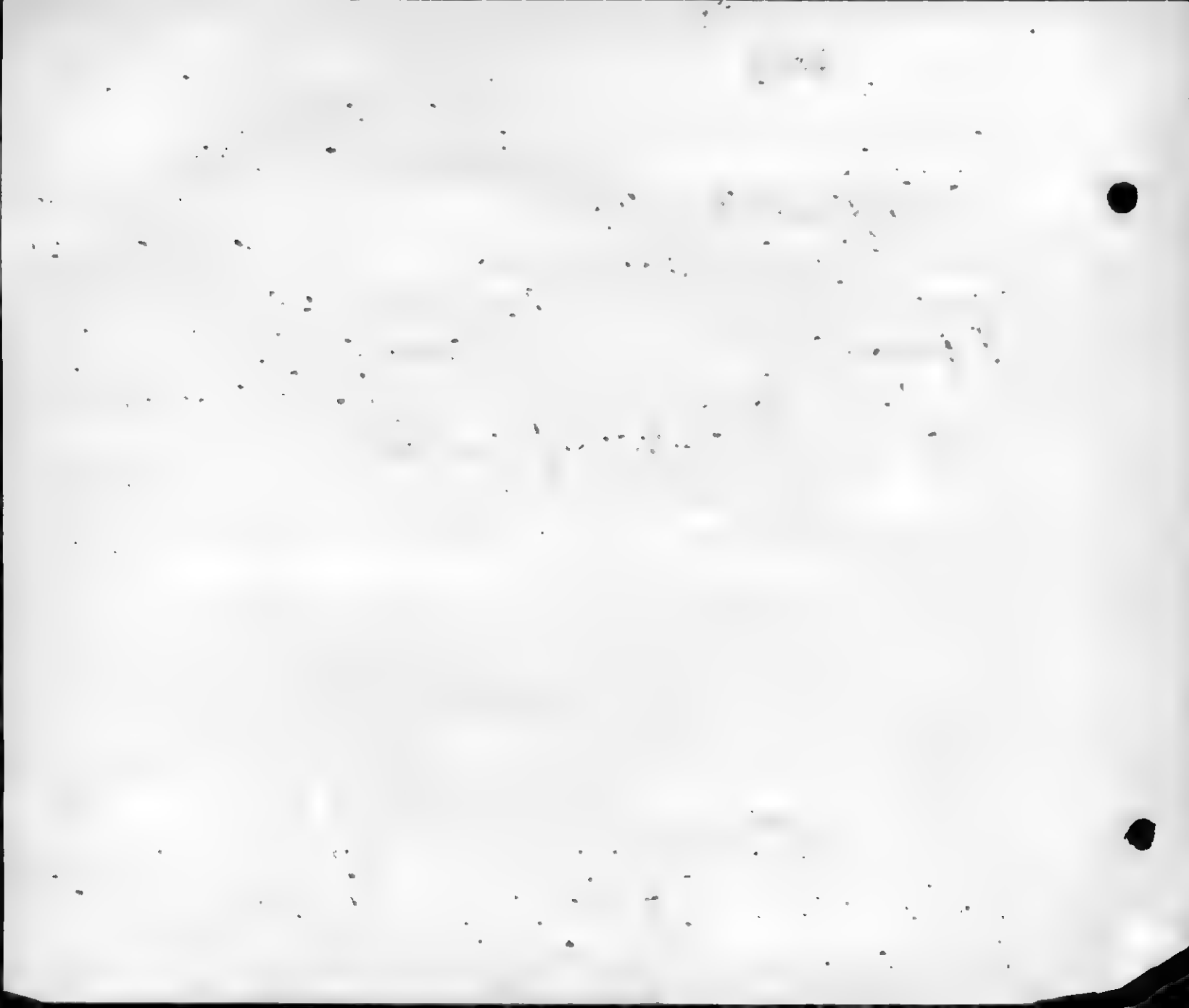
1

1501

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01480

1. PLACE OF DEATH a. COUNTY <i>Annapolis</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Annapolis</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. LENGTH OF STAY IN 1b <i>11 1/2</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>St. Agnes Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Edna</i> First <i>Simms</i> Middle Last				4. DATE OF DEATH Month <i>2</i> Day <i>2</i> Year <i>1961</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Cal</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>8-6-1911</i>	
9. AGE (In years last birthday) <i>49</i> yrs		10. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Phillip Puller</i>				14. MOTHER'S MAIDEN NAME <i>Bertha Whippin</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>216-28-3235</i>			
17. INFORMANT <i>Charles Simms</i>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Subacute Bacterial Endocarditis</i>							<i>3 wks</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Pykemia (Bleed)</i>							<i>3 wks</i>
(c) <i>Bacteraemia</i>							<i>3 wks</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan. 21, 1961</i> to <i>Feb 2, 1961</i> , that (I) (we) last saw the deceased alive on <i>Feb 2, 1961</i> , and that death occurred at <i>11</i> M, from the causes and on the date stated above							
22a. SIGNATURE <i>Theodore H. Johnson</i> M.D.				22b. DATE SIGNED <i>2/6/61</i>			
22c. PHYSICIAN'S NAME (Type) <i>Theodore H. Johnson, M. D.</i>				22d. ADDRESS <i>37 Calvert St., Annapolis, Md.</i>			
23a. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>2-8-1961</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Calvary</i>		23d. LOCATION (City, town, or county) <i>Annapolis</i> (State) <i>Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>William Beech</i>				25a. REC'D BY REGISTRAR <i>Anna M.D.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



FOR STATE  
HEALTH DEPT.

TO DEP. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please make the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

# MARYLAND STATE DEPARTMENT OF HEALTH MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01484

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Same</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. LENGTH OF STAY IN lb <b>1 Year</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Route 2 Box 325 Freetown</b>		d. STREET ADDRESS <b>Same</b>	
3. NAME OF DECEASED (Type or print) <b>Clara Elizabeth Smith</b>		4. DATE OF DEATH Month <b>February</b> Day <b>20th</b> Year <b>1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b>	8. DATE OF BIRTH <b>Aug. 5, 1888</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>72 yrs.</b>
11. BIRTHPLACE (State or foreign country) <b>Eastville, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Kelly</b>		14. MOTHER'S MAIDEN NAME <b>Easter Kelly</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>James Smith (son)</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <b>11 hours</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Gustave H. Faubert, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <b>2/20/61</b> DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/23/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Carver Memorial Park</b>		22d. LOCATION (City, town, or country) (State) <b>Laurel, P. G. Co., Md.</b>	
23. FUNERAL DIRECTOR <b>William A. Jackson Funeral Home</b>		24a. REC'D BY REGISTRAR <b>2/23/61</b>	
ADDRESS <b>916 Penna. Ave.</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Kinner</b>	

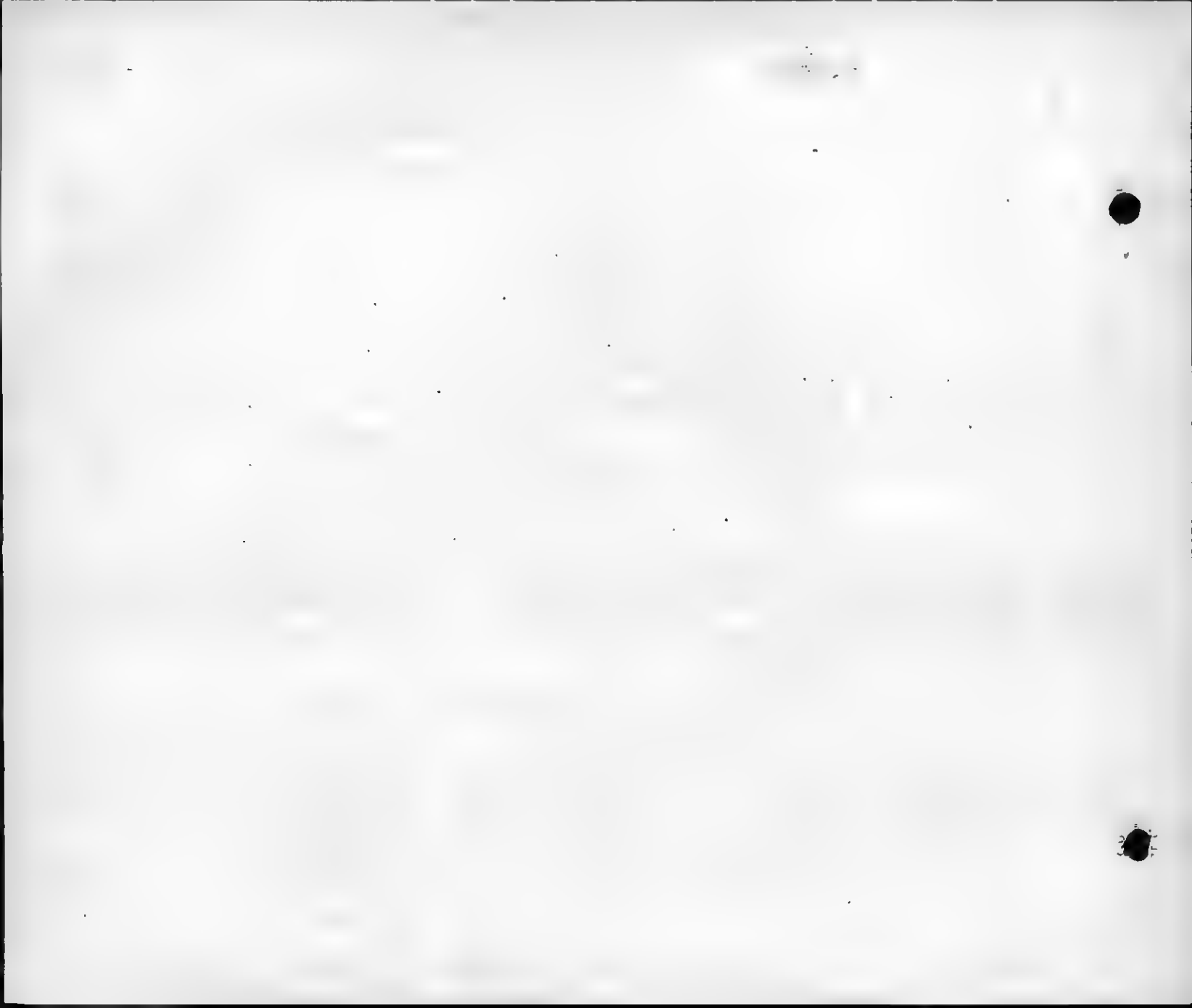


**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

01482

1503

1. PLACE OF DEATH a. COUNTY <i>a a.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>md.</i> b. COUNTY <i>a a.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>200 S. Cherry Drive Ave</i>		d. STREET ADDRESS <i>608 Sixth St</i>	
3. NAME OF DECEASED (Type or print) First <i>Howard</i> Middle <i>O.</i> Last <i>Stokes</i>		4. DATE OF DEATH Month <i>2</i> - Day <i>17</i> Year <i>1961</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 15 - 1881</i>
9. AGE (In years last birthday) <i>79</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>John G. Stokes</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Ziegler</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>✓</i>		16. SOCIAL SECURITY NO. <i>17</i>	
17. INFORMANT <i>Mary E. Stokes</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> <i>420.1</i> DUE TO (b) <i>Hypertensive Cardiac Vascular Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i> <i>2 yrs</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 4, 1955</i> to <i>2-17-1961</i> , that (I) (we) last saw the deceased alive on <i>2-17-1961</i> , and that death occurred at <i>12 PM</i> from the causes and on the date stated above			
22a. SIGNATURE <i>James R. Martin</i>		22b. DATE SIGNED <i>2-19-61</i>	
22c. PHYSICIAN'S NAME (Type) <i>JAMES R. MARTIN</i>		22d. ADDRESS <i>6 SHAW ST ANNAPOLIS, MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <i>2-20-1961</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Bluff</i>	23d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Saylor Sins</i>		25a. REC'D BY REGISTRAR DATE <i>FEB 21 '61</i>	
ADDRESS <i>Annapolis Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1504

CERTIFICATE OF DEATH

01483

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>120 South St</u>		d. STREET ADDRESS <u>120 South St.</u>	
3. NAME OF DECEASED (Type or print) <u>Carrie Starsbury Sturges</u>		4. DATE OF DEATH Month <u>2</u> Day <u>25</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-11-1886</u>
9. AGE (In years last birthday) <u>75</u> yrs		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>25</u> Hours <u>10</u> Min.	11. IF UNDER 24 HRS Months <u>10</u> Days <u>25</u> Hours <u>10</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, when retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Conner</u>		14. MOTHER'S MAIDEN NAME <u>Katie Sparks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>100-1-100000</u>	
17. INFORMANT <u>Lucie Stevens</u>		Address <u>Annapolis, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral aneurysm</u> DUE TO (b) <u>Cerebral aneurysm</u> DUE TO (c) <u>aneurysm</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2-25-61</u> to <u>2-25-61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>2-25-61</u> , and that death occurred at <u>11:30</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>A T ALLEN</u>		22d. ADDRESS <u>66 Chestnut St</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-1-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>	23d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reed</u>		25. REC'D BY REGISTRAR <u>Arthur S. Kraw</u>	
ADDRESS <u>Annapolis, Md.</u>		DATE <u>MAR 2 '61</u>	

[illegible]

1500  
1500  
1500

[illegible]

1st. 2nd. 3rd. 4th. 5th. 6th. 7th. 8th. 9th. 10th. 11th. 12th. 13th. 14th. 15th. 16th. 17th. 18th. 19th. 20th. 21st. 22nd. 23rd. 24th. 25th. 26th. 27th. 28th. 29th. 30th. 31st. 32nd. 33rd. 34th. 35th. 36th. 37th. 38th. 39th. 40th. 41st. 42nd. 43rd. 44th. 45th. 46th. 47th. 48th. 49th. 50th. 51st. 52nd. 53rd. 54th. 55th. 56th. 57th. 58th. 59th. 60th. 61st. 62nd. 63rd. 64th. 65th. 66th. 67th. 68th. 69th. 70th. 71st. 72nd. 73rd. 74th. 75th. 76th. 77th. 78th. 79th. 80th. 81st. 82nd. 83rd. 84th. 85th. 86th. 87th. 88th. 89th. 90th. 91st. 92nd. 93rd. 94th. 95th. 96th. 97th. 98th. 99th. 100th. 101st. 102nd. 103rd. 104th. 105th. 106th. 107th. 108th. 109th. 110th. 111th. 112th. 113th. 114th. 115th. 116th. 117th. 118th. 119th. 120th. 121st. 122nd. 123rd. 124th. 125th. 126th. 127th. 128th. 129th. 130th. 131st. 132nd. 133rd. 134th. 135th. 136th. 137th. 138th. 139th. 140th. 141st. 142nd. 143rd. 144th. 145th. 146th. 147th. 148th. 149th. 150th. 151st. 152nd. 153rd. 154th. 155th. 156th. 157th. 158th. 159th. 160th. 161st. 162nd. 163rd. 164th. 165th. 166th. 167th. 168th. 169th. 170th. 171st. 172nd. 173rd. 174th. 175th. 176th. 177th. 178th. 179th. 180th. 181st. 182nd. 183rd. 184th. 185th. 186th. 187th. 188th. 189th. 190th. 191st. 192nd. 193rd. 194th. 195th. 196th. 197th. 198th. 199th. 200th. 201st. 202nd. 203rd. 204th. 205th. 206th. 207th. 208th. 209th. 210th. 211th. 212th. 213th. 214th. 215th. 216th. 217th. 218th. 219th. 220th. 221st. 222nd. 223rd. 224th. 225th. 226th. 227th. 228th. 229th. 230th. 231st. 232nd. 233rd. 234th. 235th. 236th. 237th. 238th. 239th. 240th. 241st. 242nd. 243rd. 244th. 245th. 246th. 247th. 248th. 249th. 250th. 251st. 252nd. 253rd. 254th. 255th. 256th. 257th. 258th. 259th. 260th. 261st. 262nd. 263rd. 264th. 265th. 266th. 267th. 268th. 269th. 270th. 271st. 272nd. 273rd. 274th. 275th. 276th. 277th. 278th. 279th. 280th. 281st. 282nd. 283rd. 284th. 285th. 286th. 287th. 288th. 289th. 290th. 291st. 292nd. 293rd. 294th. 295th. 296th. 297th. 298th. 299th. 300th. 301st. 302nd. 303rd. 304th. 305th. 306th. 307th. 308th. 309th. 310th. 311th. 312th. 313th. 314th. 315th. 316th. 317th. 318th. 319th. 320th. 321st. 322nd. 323rd. 324th. 325th. 326th. 327th. 328th. 329th. 330th. 331st. 332nd. 333rd. 334th. 335th. 336th. 337th. 338th. 339th. 340th. 341st. 342nd. 343rd. 344th. 345th. 346th. 347th. 348th. 349th. 350th. 351st. 352nd. 353rd. 354th. 355th. 356th. 357th. 358th. 359th. 360th. 361st. 362nd. 363rd. 364th. 365th. 366th. 367th. 368th. 369th. 370th. 371st. 372nd. 373rd. 374th. 375th. 376th. 377th. 378th. 379th. 380th. 381st. 382nd. 383rd. 384th. 385th. 386th. 387th. 388th. 389th. 390th. 391st. 392nd. 393rd. 394th. 395th. 396th. 397th. 398th. 399th. 400th. 401st. 402nd. 403rd. 404th. 405th. 406th. 407th. 408th. 409th. 410th. 411th. 412th. 413th. 414th. 415th. 416th. 417th. 418th. 419th. 420th. 421st. 422nd. 423rd. 424th. 425th. 426th. 427th. 428th. 429th. 430th. 431st. 432nd. 433rd. 434th. 435th. 436th. 437th. 438th. 439th. 440th. 441st. 442nd. 443rd. 444th. 445th. 446th. 447th. 448th. 449th. 450th. 451st. 452nd. 453rd. 454th. 455th. 456th. 457th. 458th. 459th. 460th. 461st. 462nd. 463rd. 464th. 465th. 466th. 467th. 468th. 469th. 470th. 471st. 472nd. 473rd. 474th. 475th. 476th. 477th. 478th. 479th. 480th. 481st. 482nd. 483rd. 484th. 485th. 486th. 487th. 488th. 489th. 490th. 491st. 492nd. 493rd. 494th. 495th. 496th. 497th. 498th. 499th. 500th. 501st. 502nd. 503rd. 504th. 505th. 506th. 507th. 508th. 509th. 510th. 511th. 512th. 513th. 514th. 515th. 516th. 517th. 518th. 519th. 520th. 521st. 522nd. 523rd. 524th. 525th. 526th. 527th. 528th. 529th. 530th. 531st. 532nd. 533rd. 534th. 535th. 536th. 537th. 538th. 539th. 540th. 541st. 542nd. 543rd. 544th. 545th. 546th. 547th. 548th. 549th. 550th. 551st. 552nd. 553rd. 554th. 555th. 556th. 557th. 558th. 559th. 560th. 561st. 562nd. 563rd. 564th. 565th. 566th. 567th. 568th. 569th. 570th. 571st. 572nd. 573rd. 574th. 575th. 576th. 577th. 578th. 579th. 580th. 581st. 582nd. 583rd. 584th. 585th. 586th. 587th. 588th. 589th. 590th. 591st. 592nd. 593rd. 594th. 595th. 596th. 597th. 598th. 599th. 600th. 601st. 602nd. 603rd. 604th. 605th. 606th. 607th. 608th. 609th. 610th. 611th. 612th. 613th. 614th. 615th. 616th. 617th. 618th. 619th. 620th. 621st. 622nd. 623rd. 624th. 625th. 626th. 627th. 628th. 629th. 630th. 631st. 632nd. 633rd. 634th. 635th. 636th. 637th. 638th. 639th. 640th. 641st. 642nd. 643rd. 644th. 645th. 646th. 647th. 648th. 649th. 650th. 651st. 652nd. 653rd. 654th. 655th. 656th. 657th. 658th. 659th. 660th. 661st. 662nd. 663rd. 664th. 665th. 666th. 667th. 668th. 669th. 670th. 671st. 672nd. 673rd. 674th. 675th. 676th. 677th. 678th. 679th. 680th. 681st. 682nd. 683rd. 684th. 685th. 686th. 687th. 688th. 689th. 690th. 691st. 692nd. 693rd. 694th. 695th. 696th. 697th. 698th. 699th. 700th. 70

544

22 2221-11-5

4/15 - 1950

2. *Staphylinus*

Just signed contract.

10-1-8 - 10-1-8 - 10-1-8  
 10-1-8 - 10-1-8 - 10-1-8



# 1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1503

## CERTIFICATE OF DEATH

Reg. Dist. No. 01485

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A-A</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>				c. LENGTH OF STAY IN 1b <u>X</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Riverdale &amp; Inverness Roads</u> 1				4. STREET ADDRESS <u>Severna Park Rd</u>			
3. NAME OF DECEASED (Type or print) <u>KATRINA</u> Middle Last <u>Swindell</u>				4. DATE OF DEATH 2 - 5 - 61			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 6, 1886</u> 74 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Balto, Md</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>John Moser</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO			
17. INFORMANT <u>Son Mr. J. Warren Swindell</u>				Address <u>Box 221 Route #2 Severna Park, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive C.V. Disease</u> DUE TO (c) <u>Generalized Atherosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>1960</u> 19 to <u>1961</u> 19, that I last saw the deceased alive on <u>12-20-60</u> 19, and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Robert R. Holm</u> M.D.				ADDRESS (Street, city or town, state) <u>Severna Park Rd 2-5-61</u> DATE SIGNED <u>Md.</u>			
PHYSICIAN'S NAME (Type) <u>Robert R. Holm</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-8-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Tucker Sons</u>				ADDRESS <u>Balto 17, Md</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 8 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

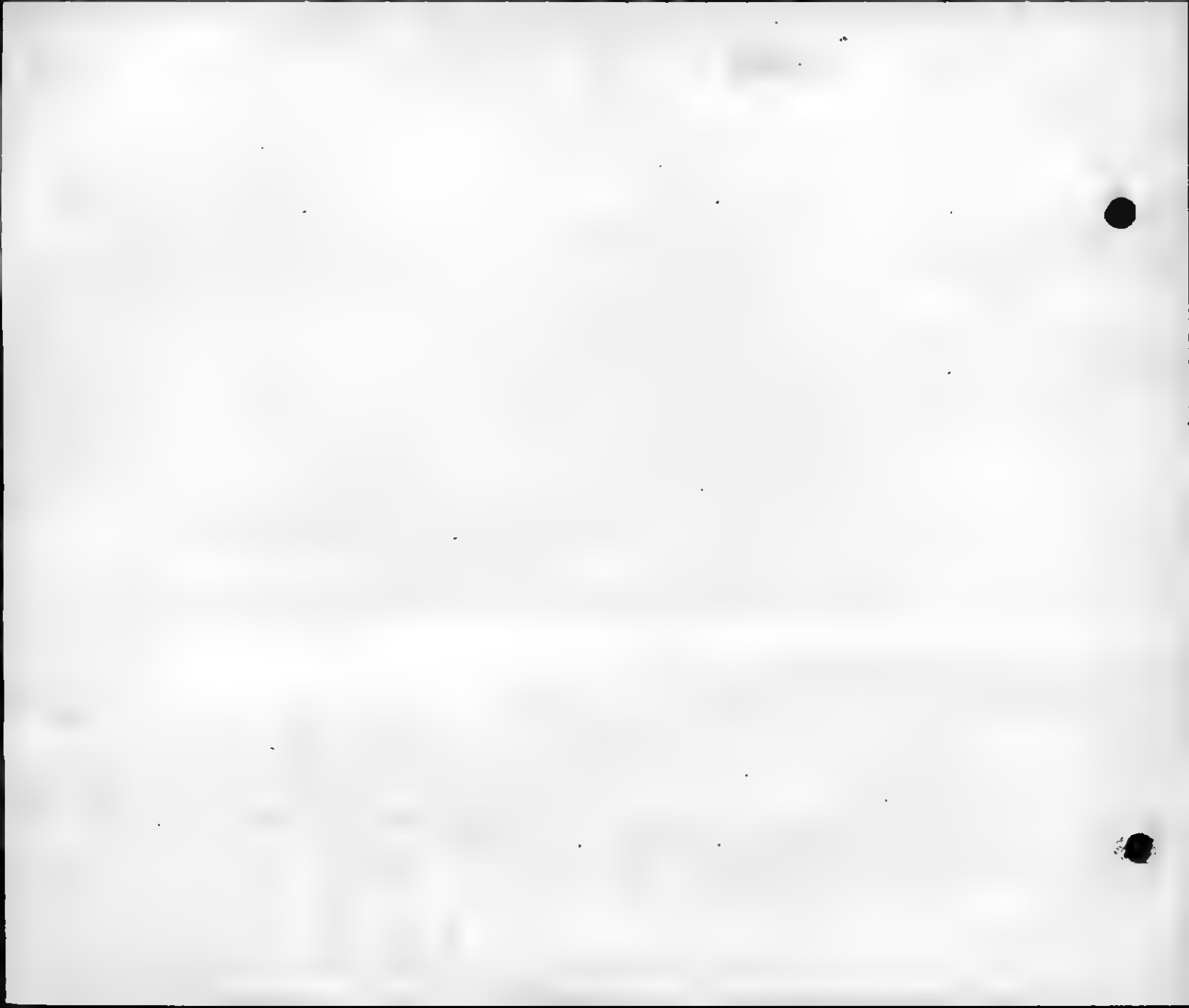


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

1  
M  
I  
0  
1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
1506  
CERTIFICATE OF DEATH  
01486

1. PLACE OF DEATH a. COUNTY <u>H.H.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>H.H.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>11111</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>11111</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11111</u>				d. STREET ADDRESS <u>11111</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>71111</u> Last <u>71111</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>12</u> Year <u>1961</u>					
5. SEX <u>1</u>	6. COLOR OR RACE <u>11111</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>11-11-1111</u>	9. AGE (In years lost birthday) yrs <u>11</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min <u>11</u>	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>11111</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>11111</u>		11. BIRTHPLACE (State or foreign country) <u>11111</u>	
12. CITIZEN OF WHAT COUNTRY? <u>11111</u>							
13. FATHER'S NAME <u>11111</u>				14. MOTHER'S MAIDEN NAME <u>11111</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>11111</u>		16. SOCIAL SECURITY NO. <u>11111</u>		17. INFORMANT <u>11111</u>		Address <u>11111</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>11111</u> DUE TO <u>11111</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>11111</u> DUE TO <u>11111</u> (c) <u>11111</u> DUE TO <u>11111</u>				INTERVAL BETWEEN ONSET AND DEATH <u>11111</u> days			
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>11111</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>11</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11</u> <u>57</u> to <u>Feb.</u> <u>61</u> , that (I) (we) last saw the deceased alive on <u>Feb.</u> <u>12</u> <u>1961</u> , and that death occurred at <u>2:45</u> from the causes and on the date stated above							
22a. SIGNATURE <u>11111</u>				22b. DATE SIGNED <u>Feb. 14, 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>Francis I. Codd M.D.</u>				22d. ADDRESS <u>11111</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>11111</u>		23b. DATE THEREOF <u>11-11-11</u>		23c. NAME OF CEMETERY OR CREMATORY <u>11111</u>		23d. LOCATION (City, town, or county) (State) <u>11111</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>11111</u> ADDRESS <u>11111</u>				25a. REC'D BY REGISTRAR <u>11111</u> DATE <u>FEB 17 '61</u>		25b. REGISTRAR'S SIGNATURE <u>11111</u>	

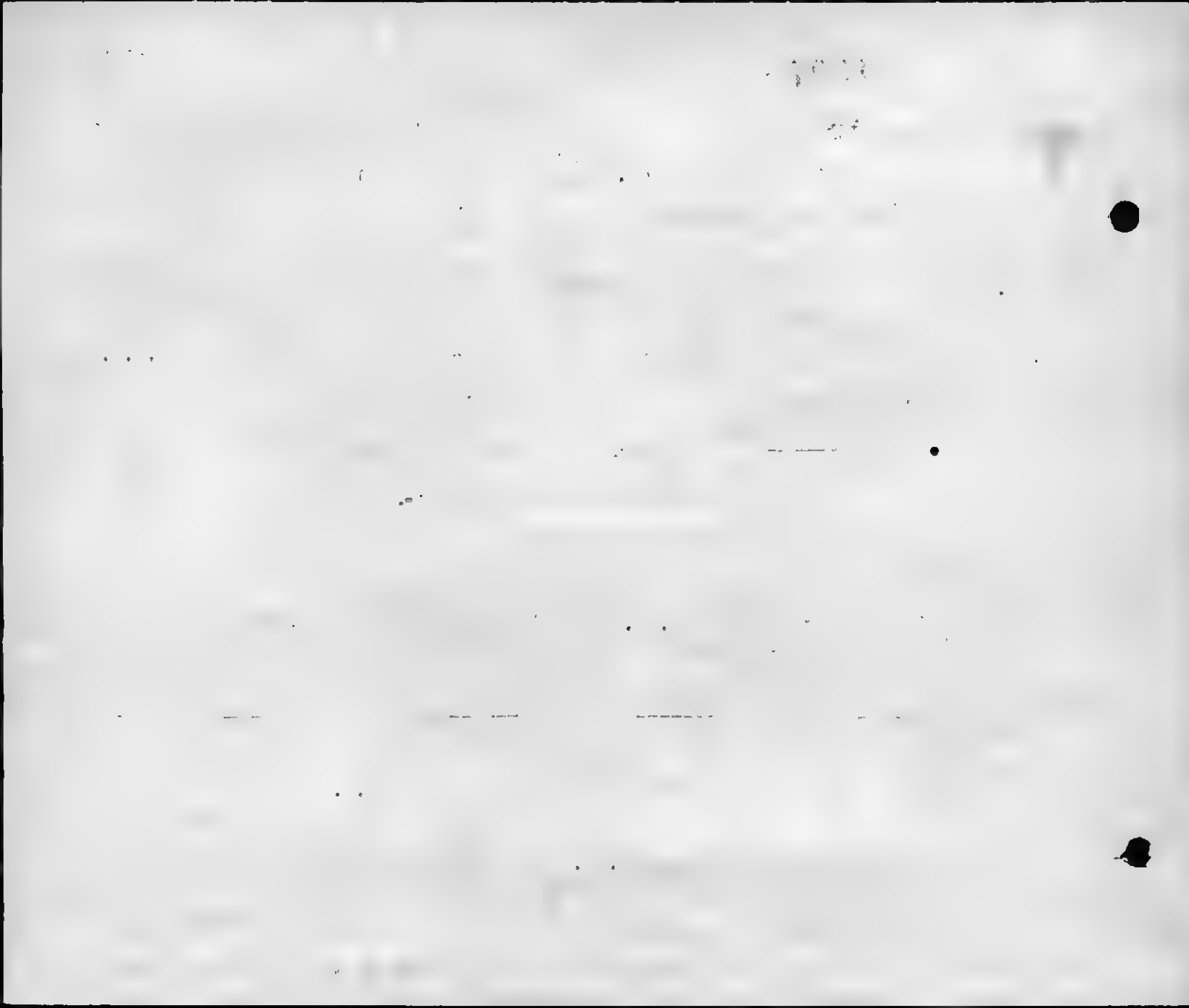


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased is not a resident of the State, the certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

YR A15 (4)  
15M 9/60

1  
1507  
M  
I  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
01487

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Queen Anne	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY in 1b 17 years 6 mos. 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		d. STREET ADDRESS Unknown		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Alex Thomas		4. DATE OF DEATH Month Day Year 2 27 1961			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1898		9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Thomas		14. MOTHER'S MAIDEN NAME Lilly Cooper	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter on y one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 162.1 Aspiration Bronchopneumonia Bronchogenic Carcinoma DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Chronic Brain Syndrome asso. w. Syphilis of the Central Nervous System Meningo-Encephalitic Type		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While working <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, store, bldg., etc.)	
20f. (City or town) 8/25		20g. (County) 1943		20h. (State) 2/27/1961	
21. I certify that (I) (this hospital) attended the deceased from 8/25 to 2/27/1961, that (I) (we) last saw the deceased alive on 2/27/1961, and that death occurred at 9:25 p.m. from the causes and on the date stated above.		22a. SIGNATURE Lionel McHenry Mapp, M. D.		22b. DATE SIGNED 2/28/61	
22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 3/2/61		23c. NAME OF CEMETERY OR CREMATORY Univ. Of Md.	
23d. LOCATION (City, town or county) Baltimore, Md.		23e. REC'D BY REGISTRAR Wm. Reese II		23f. REGISTRAR'S SIGNATURE Catherine L. Kenna	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, or to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

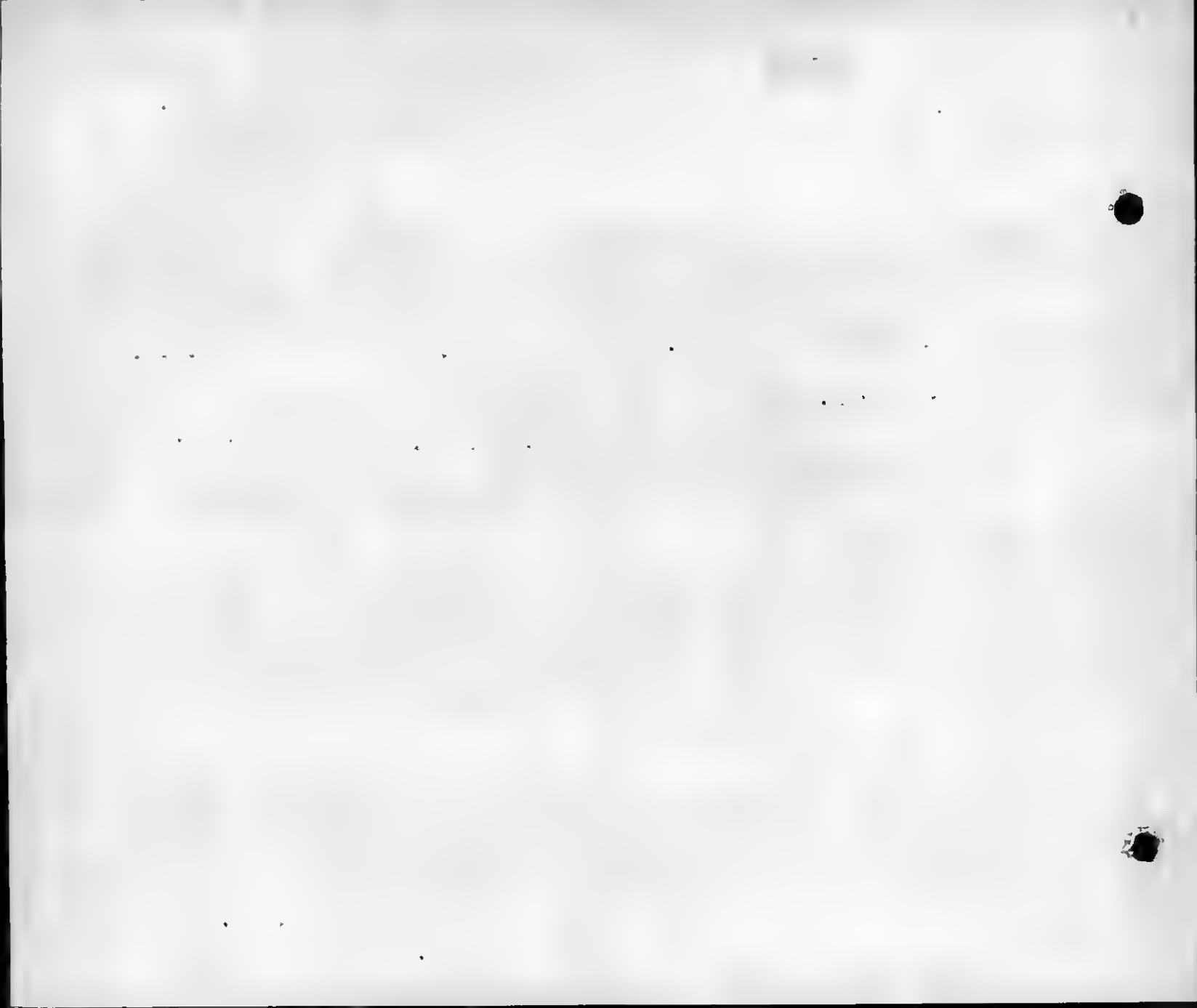
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1508

Items 1, 4, 9 Film 2-10-61 et

Reg. Dist. No. 01488

1. PLACE OF DEATH a. COUNTY <b>AA CO</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS - MD.</b> c. LENGTH OF STAY IN 1b <b>10 ANNAPOLIS -</b>			2. USUAL RESIDENCE (Where deceased lived If Institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>AA CO</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 ANNAPOLIS -</b> d. STREET ADDRESS <b>1 419 Second St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>NORA</b> Middle <b>E.</b> Last <b>TILGHMAN</b>			4. DATE OF DEATH Month <b>February</b> Day <b>1</b> Year <b>19 61</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/31/80</b>	9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Va.</b>	
13. FATHER'S NAME <b>George H. Tull</b>			14. MOTHER'S MAIDEN NAME <b>Sally Collin</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. M. S. Saller 219 Second St. Annapolis</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardiorespiratory Disorder</b> <b>1443x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)					INTERVAL BETWEEN ONSET AND DEATH <b>2 YRS.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE <b>E. Linhardt</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>F. Linhardt</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>2-1-61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>2-4-1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rehoboth Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Rehoboth, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Levin R. Wilkins</b>		ADDRESS <b>Princess Anne, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 28 7 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

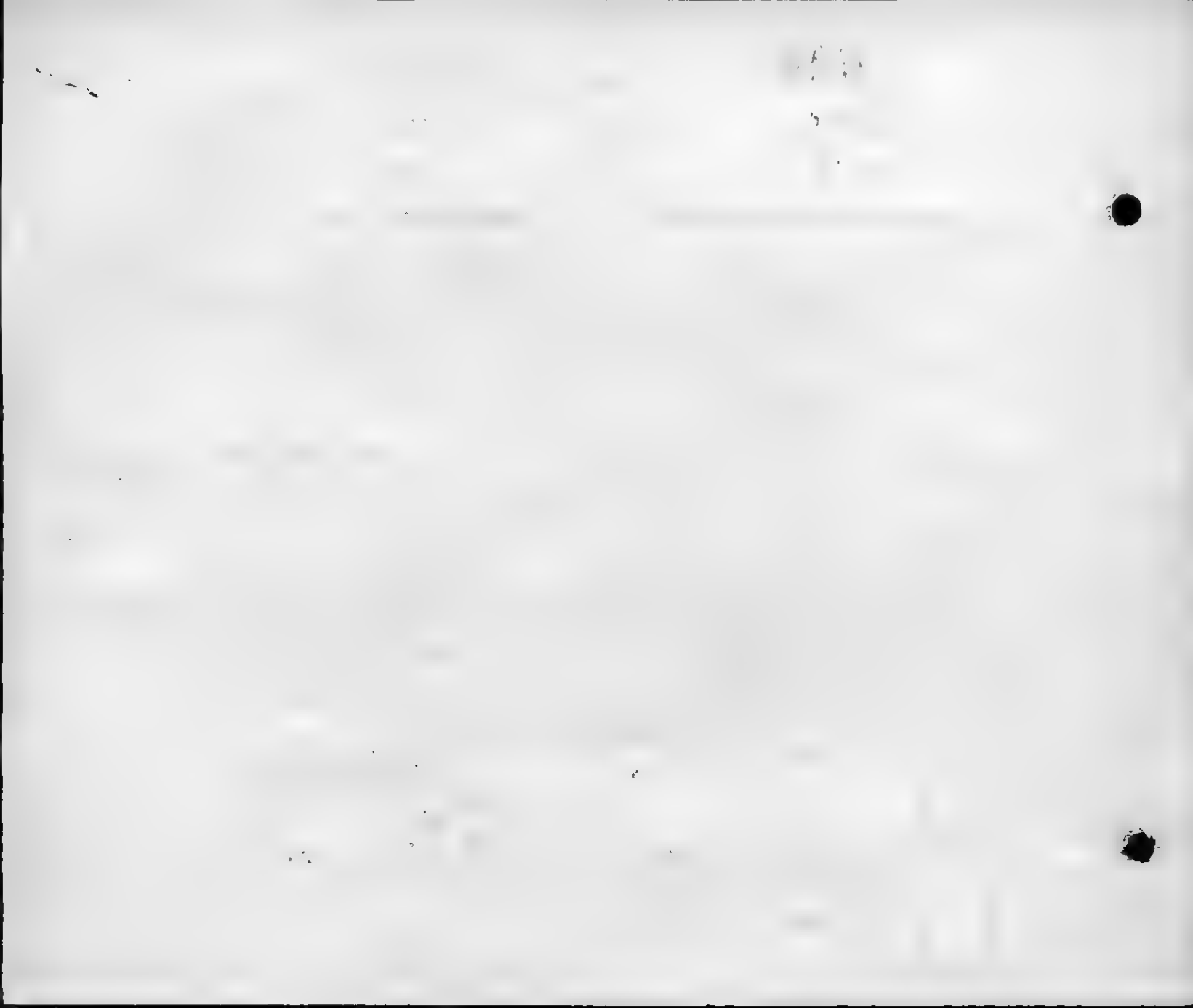
1509

## CERTIFICATE OF DEATH

Item 8 Film G282 3/7/61 mh

01489

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN IL <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b>		d. STREET ADDRESS <b>Box 26, Lake Shore Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Allec (Vodsky) VODORSKY</b>		4. DATE OF DEATH Month <b>2</b> Day <b>25</b> Year <b>1961</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/23/1886</b>		9. AGE (in years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>4</b>		11. IF UNDER 24 HRS. Hours <b>7</b> Min. <b>4</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Rigger (Ref)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Garment</b>		11. BIRTHPLACE (County & State, or foreign country) <b>U.S.S.R.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-10-9612</b>		17. INFORMANT <b>Clyde Stacy - Lake Shore Dr., Pasadena, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>720.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Cardiac failure</b> DUE TO (c) <b>Coronary disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour <b>19</b> a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>2/23/1961</b>		20g. (County) <b>2/25/1961</b>	
21. I certify that (I) (the undersigned) attended the deceased from <b>2/23/1961</b> to <b>2/25/1961</b> that (I) (we) last saw the deceased alive on <b>2/24/1961</b> , and that death occurred at <b>2:30 PM</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>Gerard Church</b>		22b. DATE SIGNED <b>2/25/61</b>		22c. PHYSICIAN'S NAME (Type) <b>GERARD CHURCH</b>		22d. ADDRESS <b>121 PATRICK ST ANNAPOLIS</b>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/>		22f. MED. DIRECTOR <input type="checkbox"/>		22g. STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		23b. DATE THEREOF <b>Feb. 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cem.</b>		23d. LOCATION (City, town or county) <b>Glen Burnie, Md.</b>		23e. REC'D BY REGISTRAR <b>R. V. Dingledine</b>		23f. REGISTRAR'S SIGNATURE <b>Glen Burnie, Md.</b>		23g. DATE <b>MAR 1 '61</b>		23h. REGISTRAR'S SIGNATURE <b>Charles S. Thomas</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1510

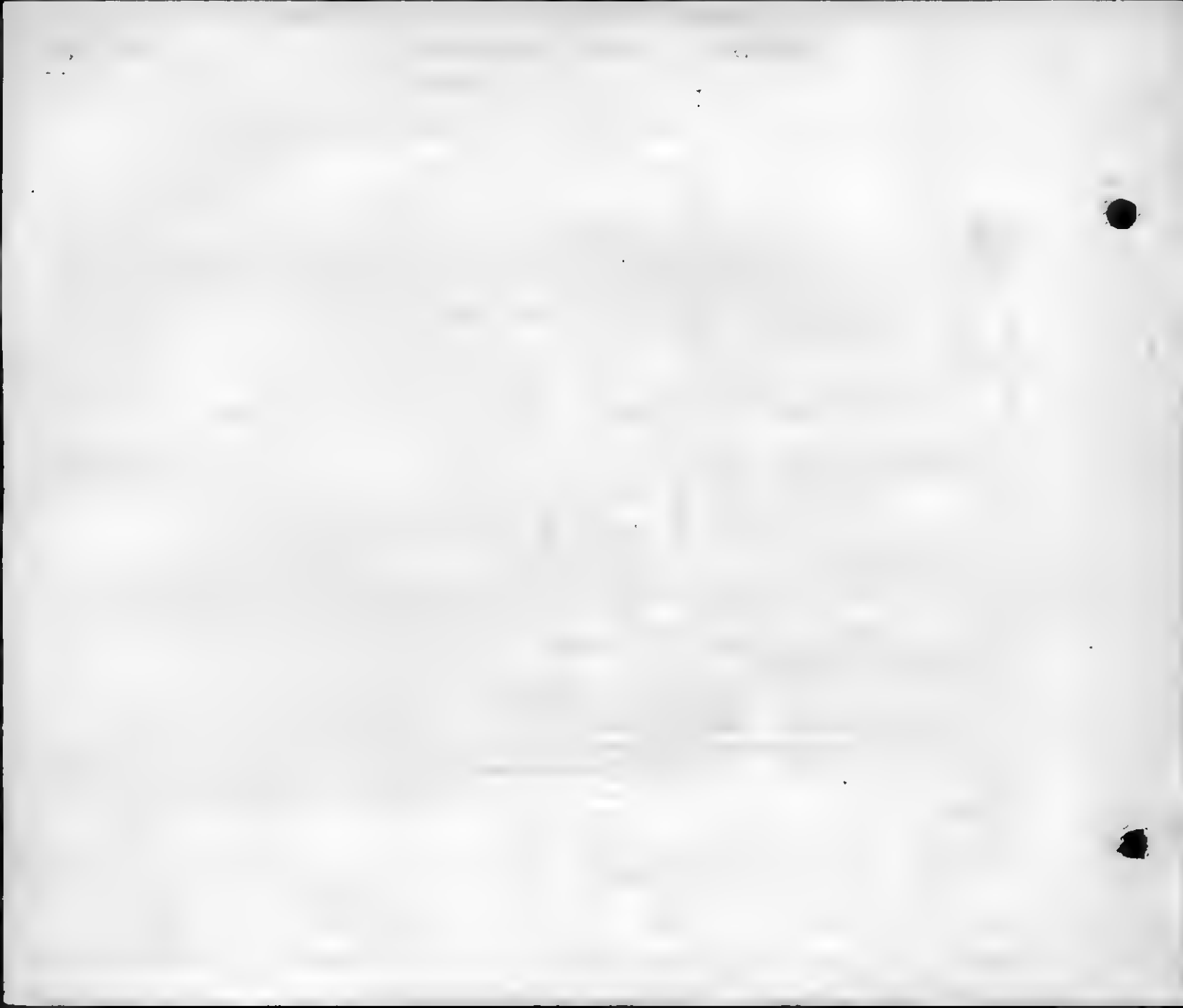
## CERTIFICATE OF DEATH

Reg. Dist. No.

02656

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>				c. LENGTH OF STAY IN 1b <b>5y. 4m. 13d.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Crownsville State Hospital</b>				e. STREET ADDRESS <b>1118 Etting St.</b>			
3. NAME OF DECEASED (Type or print) First <b>Malinda</b> Middle <b>Elizabeth</b> Last <b>Williams</b>				4. DATE OF DEATH Month <b>2</b> Day <b>25</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>? 3-7-1880</b>	
9. AGE (In years lost birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months <b>2</b> Days <b>25</b> Hours <b>19</b> Min.		IF UNDER 24 HRS Months <b>2</b> Days <b>25</b> Hours <b>19</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO <b>Unknown</b>		17. INFORMANT <b>Hospital Records.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH <b>2 months.</b>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b>							
DUE TO (b) <b>Arteriosclerotic Hypertensive Cardio Vascular Disease</b>							<b>years.</b>
DUE TO (c) <b>---</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>CHRONIC BRAIN SYNDROME ASS. WITH GEN ARTERIOSCLEROSIS</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>---</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>---</b> p. m. <b>---</b> 19 <b>61</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Net while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>---</b>	
20f. (City or town) <b>---</b>				20g. (County) <b>---</b>		20h. (State) <b>---</b>	
21. I certify that I attended the deceased from <b>10/12</b> , 19 <b>55</b> , to <b>2/25/61</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>4/25/61</b> , 19 <b>61</b> , and that death occurred at <b>3:10 P.M.</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>CROWN SVILLE STATE HOSPITAL</b>				DATE SIGNED <b>---</b>			
ACTUAL SIGNATURE <b>L. BENEDICT M.D.</b>				M.D. <b>CROWN SVILLE STATE HOSPITAL</b>			
PHYSICIAN'S NAME (Type) <b>L. BENEDICT M.D.</b>				<b>CROWN SVILLE, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/1/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Charles Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>St. Charles, Md. VA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. O. Wilson</b>				ADDRESS <b>1000 Brantley Ave.</b>		24a. REGISTRY SIGNATURE <b>---</b>	
24b. REGISTRY SIGNATURE <b>---</b>				DATE <b>MAR 16 '61</b>		24c. REGISTRY SIGNATURE <b>---</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, 4 may be retained by the hospital or attending physician.

M

I

MEDICAL CERTIFICATION

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

01490

1. PLACE OF DEATH  
a. COUNTY **Anne Arundel**  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Crownsville**  
c. LENGTH OF STAY (N 1b) **6 mos. 9 days**  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Crownsville State Hospital**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE **Maryland** b. COUNTY **Baltimore City**  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Baltimore**  
d. STREET ADDRESS **1520 N. Eutaw Place**  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) **Mae**  
4. DATE OF DEATH **2 15 19 61**  
5. SEX **Female** 6. COLOR OR RACE **Negro** 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 8. DATE OF BIRTH **11/6/1900** 19. AGE (In years if UNDER 1 YEAR last b. Months Days Hours Min. **60** IF UNDER 24 HRS.)

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Unemployed** 10b. KIND OF BUSINESS OR INDUSTRY **Unknown** 11. COUNTY & State, or foreign country) **Maryland** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Unknown** 14. MOTHER'S MAIDEN NAME **Elizabeth Jones**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No** 16. SOCIAL SECURITY NO. **Unknown** 17. INFORMANT **Hospital Records** Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **Pulmonary Edema**  
DUE TO (b) **Arteriosclerotic Cardiovascular Disease**  
DUE TO (c) **with Hypertension**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) **Chronic Brain Syndrome asso with Cerebral Arteriosclerosis**

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐ 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year **6/8/ 19 60** 20d. INJURY OCCURRED **at work** 20e. PLACE OF INJURY (Home, farm, factory, etc.) **at work** 20f. (City or town) **Crownsville** (County) **Anne Arundel** (State) **Md.**

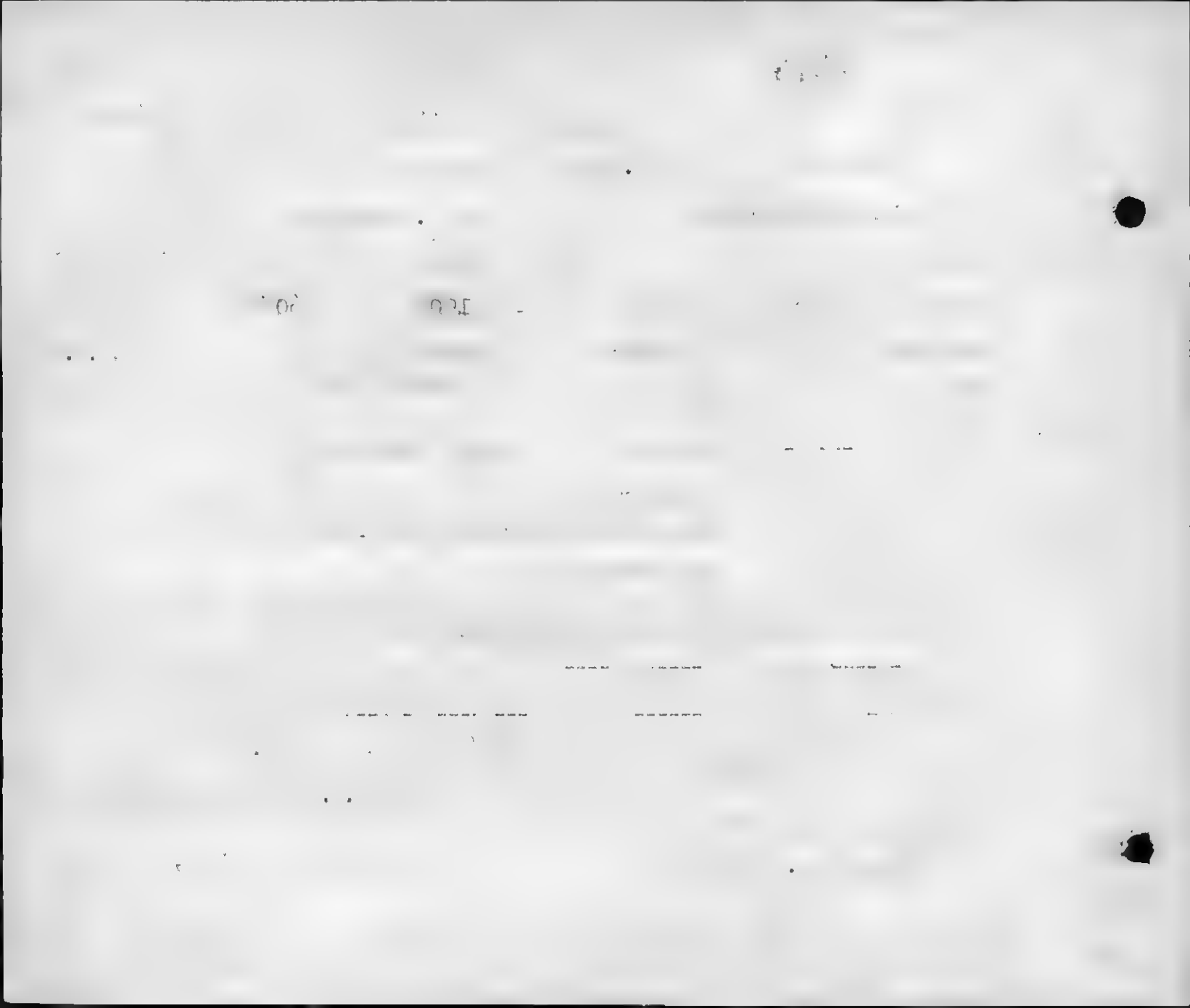
21. I certify that (I) (this hospital) attended the deceased from **6/8/ 19 60** to **2/15/ 19 61** that (I) (we) last saw the deceased alive on **2/15/ 19 61** and that death occurred at **8:15** from the causes and on the date stated above.

22a. SIGNATURE **Hildegard H. Reissmann** 22b. DATE SIGNED **2/15/61**  
22c. PHYSICIAN'S NAME (Type or print) **Hildegard H. Reissmann** 22d. ADDRESS **Crownsville State Hospital, Maryland**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE THEREOF **2/20/61** 23c. NAME OF CEMETERY OR CREMATORY **mt auburn** 23d. LOCATION (City, town or county) **md.** (State)

24. FUNERAL DIRECTOR'S SIGNATURE **Geo. S. Nelson** ADDRESS **1348 N. Calhoun St**

25a. REC'D BY REGISTRAR **FEB 20 '61** 25b. REGISTRAR'S SIGNATURE **Arthur S. Kraus**



1  
TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
1512  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01491

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 10 mo, 13 d. d. STREET ADDRESS 1643 W. North Str.				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Md b. COUNTY Balto, City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Md. d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Allie ALBERT Woods First Middle Last				4. DATE OF DEATH 2 25 19 61 Month Day Year			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-11-1886 yrs. day	
9. AGE (In years last birthday) 74		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed				10b. KIND OF BUSINESS OR INDUSTRY --			
13. FATHER'S NAME Bolder Woods				14. MOTHER'S MAIDEN NAME Susan Oliver			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown				16. SOCIAL SECURITY NO. unknown			
17. INFORMANT Hospital Records				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last, (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome assoc. with Senility						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/12 1960 to 2/25 1961, that (I) (we) last saw the deceased alive on 2/25 1961, and that death occurred at 2:40 A.M. from the causes and on the date stated above.						22a. SIGNATURE [Signature] 22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Leon W. Whit, M.D.				22d. ADDRESS Crownsville State Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-28-61		23c. NAME OF CEMETERY OR CREMATORY [Signature]		23d. LOCATION (City, town or county) (State) Md	
24. FUNERAL DIRECTOR'S SIGNATURE [Signature] 24b. ADDRESS 1348 N. Calhoun St				25a. REC'D BY REGISTRAR DATE FEB 27 '61		25b. REGISTRAR'S SIGNATURE [Signature]	

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1513

01492

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>AA</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3 Shoreland Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Faith</b> Middle <b>Young</b> Last <b>Young</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>26</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 21, 1960</b>
9. AGE (In years last birthday) yrs. <b>2</b>		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>5</b> Hours <b>Min.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Annapolis, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James E. Young</b>		14. MOTHER'S MAIDEN NAME <b>Martha Ann Jones</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>James E. Young, same as 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>795.0</b> DUE TO <b>Asphyxia due to undetermined cause</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Asphyxia due to undetermined cause</b> (c) <b>Asphyxia due to undetermined cause</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Asphyxia due to undetermined cause</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 26, 1961</b> to <b>Feb 26, 1961</b> , that (I) (we) lost saw the deceased alive on <b>Feb 26, 1961</b> and that death occurred at <b>8AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>James W. Hayes</b> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>James W. Hayes</b>		22d. ADDRESS <b>Medical Arts Bldg</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>Feb 28, 61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven</b>	23d. LOCATION (City, town, or county) (State) <b>Glen Burnie Md</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping &amp; KIRKLEY</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 2 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		25c. REGISTRAR'S SIGNATURE	

CHIEF OF BUREAU